Filing at a Glance

Company:	CareFirst BlueChoice, Inc.
Product Name:	2020 DC CFBC Student Health Plan
State:	District of Columbia
TOI:	HOrg02G Group Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02G.002C Any Size Group - HMO
Filing Type:	Form
Date Submitted:	12/13/2019
SERFF Tr Num:	CFBC-132190326
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	DC SHP CFBC
Implementation Date Requested:	08/01/2020
Author(s):	Aisha Kane-Washington, Amy Gill, Jill Schwartz, Rachel Peters, Britney Tyler, Gina Harrison, Damiki Hearn, Ashley Carter, Paula Mays
Reviewer(s):	Colin Johnson (primary), RaShaunda Benson
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: *District of Columbia* **Filing Company:** *CareFirst BlueChoice, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*
Product Name: *2020 DC CFBC Student Health Plan*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Ashley Carter

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Non Employer Group - Individual
Filing Status Changed: 12/17/2019
State Status Changed:
Created By: Ashley Carter
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Attached for your review and approval are copies of the above-referenced forms in their final versions. These forms will be used to create new non-grandfathered student health plans for the group market. The new rate information will be submitted under separate cover.

The intent of this filing is to secure approval of student health benefit plans that we wish to offer in the marketplace for the 2020-2021 academic year. Upon approval of the forms submitted under this filing, the following forms will be used to create our 2020-2021 student health plan BlueChoice Advantage product. For this product, the In-Network portion is underwritten by CareFirst BlueChoice, Inc., and the Out-of-Network portion is underwritten by Group Hospitalization and Medical Services, Inc.

Company and Contact

Filing Contact Information

Aisha Kane-Washington, Senior Contract Specialist
840 First Street NE
Washington, DC 20065

aisha.kane-washington@carefirst.com
202-680-5236 [Phone]
202-680-7625 [FAX]

Filing Company Information

CareFirst BlueChoice, Inc.
840 First Street NE
Washington, DC 20065
(202) 479-8000 ext. [Phone]

CoCode: 96202
Group Code:
Group Name:
FEIN Number: 52-1358219

State of Domicile: District of Columbia
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #: CFBC-132190326 **State Tracking #:** **Company Tracking #:** DC SHP CFBC

State: District of Columbia **Filing Company:** CareFirst BlueChoice, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO
Product Name: 2020 DC CFBC Student Health Plan
Project Name/Number: /

Form Schedule

Lead Form Number: DC/CFBC/SHP/2020 AMEND (8/20)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Academic Institution Contract Application	DC/CFBC-CF/SHP/AICA/POS (8/20)	AEF	Initial			DC CFBC SHP POS_AICA_ (8-20).pdf
2		Academic Institution Contract	DC/CFBC/SHP/POS IN/AIC (8/20)	POLA	Initial			DC CFBC SHP POS INN_AIC_ (8-20).pdf
3		Student Health Plan Individual Enrollment Agreement	DC/CFBC/SHP/ POS IN/IEA (8/20)	POLA	Initial			DC CFBC SHP POS INN_IEA (8-20).pdf
4		Continuation of Coverage Rider	DC/CFBC/SHP CONT PRIV (8/20)	POLA	Initial			DC CFBC SHP CONT PRIV (8-20).pdf
5		Family Planning Rider	DC/CFBC/SHP/FAM PLAN (8/20)	POLA	Initial			DC CFBC SHP FAM PLAN (8-20) Rider.pdf
6		Morbid Obesity Rider	DC/CFBC/SHP/MORBID OBESITY (R. 8/20)	POLA	Initial			DC-CFBC-SHP-MORBID OBESITY (R 8-20) CFBC.pdf
7		2020 Amendment	DC/CFBC/SHP/2020 AMEND (8/20)	POLA	Initial			DC-CFBC-SHP POS IN 2020 AMEND (8-20).pdf
8		Prior Authorization Amendment	DC/CFBC/SHP/AUTH AMEND/HMO (8/20)	POLA	Initial			DC-CFBC-SHP-AUTH AMEND-HMO (8-20).pdf
9		Schedule of Benefits	DC/CFBC/SHP/POS IN SOB (8/20)	SCH	Initial			DC CFBC SHP POS INN_SOB_ (8-20).pdf

SERFF Tracking #:	*CFBC-132190326*	***State Tracking #:***		***Company Tracking #:***	*DC SHP CFBC*

State:	*District of Columbia*	***Filing Company:***	*CareFirst BlueChoice, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO*		
Product Name:	*2020 DC CFBC Student Health Plan*		
Project Name/Number:	*/*		

Lead Form Number: DC/CFBC/SHP/2020 AMEND (8/20)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
10		Schedule of Benefits	DC/CFBC/SHP/POS/IN/TO/ SOB (8/20)	SCH	Initial			DC CFBC SHP POS INN TO_SOB_(8-20).pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NAP**	Network Access Plan
NOC	Notice of Coverage	**OTH**	Other
OUT	Outline of Coverage	**PJK**	Policy Jacket
POL	Policy/Contract/Fraternal Certificate	**POLA**	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider
PRC	Provider Contract/Provider Addendum/Provider Leading Agreement	**PRD**	Provider Directory

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

STUDENT HEALTH PLAN
ACADEMIC INSTITUTION CONTRACT APPLICATION
For Point-of-Service Products

Point-of-Service is a jointly offered product with in-network benefits provided under separate contract by CareFirst BlueChoice, Inc. (CareFirst BlueChoice) and out-of-network benefits provided under separate contract by CareFirst (collectively referred to in this Application as CareFirst/CareFirst BlueChoice). With a point-of-service product, the Member may choose each time that services are sought to qualify for HMO benefits under the in-network plan or to receive traditional indemnity benefits under the out-of-network plan.

If this Application is being completed for a new Academic Institution or an existing Academic Institution selecting a new product or making a jurisdictional change, the Academic Institution is required to complete this Application in its entirety, in black ink, and sign, date and return it to the Academic Institution's Sales Representative.

If this Application is being completed for an existing Academic Institution amending the Academic Institution's current coverage, or changing general information, the Academic Institution is required to complete, in black ink, *only* the sections in which the information is changing, sign, date, and return this Application to the Academic Institution's Sales Representative.

Do not alter this document except to fill in the blanks and check the boxes provided. This Application will not be accepted if any other changes are made.

GENERAL INFORMATION

Academic Institution Number (if available): _____

Name of Organization: _____

Physical Location:

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if other than above):

Street Address: _____

City: _____ State: _____ Zip: _____

Billing Address (if other than above):

Street Address: _____

City: _____ State: _____ Zip: _____

Billing Contact:

Name:_____ Telephone Number: _____

Title: _____

Email Address: _____

Academic Institution Administrator (Person to Contact):

Name:_____ Telephone Number: _____

Title: _____

Email Address: _____

Chief Executive Officer/President

Name:_____ Telephone Number: _____

Title: _____

Email Address: _____

Federal Tax Identification Number: _____

BILLING FREQUENCY

The Academic Institution chooses to make payments:

- ☐ In monthly installments
- ☐ In two installments within the Contract Year
- ☐ In one lump sun.

ACADEMIC INSTITUTION CONTRIBUTION

Medical Products

CareFirst/CareFirst BlueChoice will notify the Academic Institution of any rate adjustments no later than forty-five (45) days prior to the effective date of the rate change.

Annual Enrollment Certification
CareFirst/CareFirst BlueChoice reserves the right to inspect the records of the Academic Institution in order to verify the eligibility of students and their dependents. In addition, the Academic Institution agrees to complete and return to CareFirst/CareFirst BlueChoice an eligibility audit and/or census report annually.

ENROLLMENT ELIGIBILITY REQUIREMENTS

All individuals who are defined as being eligible for coverage as Subscribers [(and any Dependents)] in the Academic Institution's written student benefit policies, as amended from time to time., are eligible to enroll as long as they meet the additional eligibility and enrollment requirements stated in the Individual Enrollment Agreement and any attachments thereto. *CareFirst/CareFirst BlueChoice reserves the right to review, prior to the effective date, the Academic Institution's written student benefit policies applicable to the product selected for compliance with all applicable laws.*

Note: No individual is eligible to enroll under the Academic Institution's coverage both as a Subscriber and as a Dependent. If both spouses of a family (or both Domestic Partners, if applicable) are Eligible Students of the Academic Institution, they may not both select a type of coverage that is Individual and Adult Coverage or Family Coverage.

CareFirst/CareFirst BlueChoice may at reasonable times examine the Academic Institution's pertinent records with respect to eligibility and premium payments. CareFirst/CareFirst BlueChoice may establish reasonable requirements of proof to confirm the eligibility of Members. The Academic Institution agrees to provide, within thirty-one (31) days of request, any information that verifies its compliance with the enrollment guidelines.

ENROLLMENT EFFECTIVE DATES

Coverage of the following eligible individuals becomes effective on the date that the Academic Institution Contract becomes effective:

1. Existing eligible individuals who are currently enrolled under the Academic Institution's prior health coverage;

2. Eligible individuals who enroll during an open enrollment period established by the Academic Institution and CareFirst/CareFirst BlueChoice.

ACADEMIC INSTITUTION'S RESPONSIBILITY TO ELIGIBLE STUDENTS

The Academic Institution must:

1. Advise the Eligible Student of his/her eligibility for coverage under the Academic Institution Contract;

2. Advise the Eligible Student when she/he may enroll for such coverage in accordance with the provisions stipulated in this Application and the Academic Institution Contract including the Individual Enrollment Agreement;

3. Advise the Eligible Student when coverage will commence based on the aforementioned provisions and the date of completion of the enrollment form or other acceptable form of consent established by the Academic Institution;

4. Advise the Eligible Student of the cost of such coverage to the student and the method in which payment is to be made; and

5. Obtain from the Eligible Student a completed enrollment form or other acceptable form of consent established by the Academic Institution and a signed agreement by the student to pay the applicable premium.

ACADEMIC INSTITUTION STATEMENTS

The Academic Institution agrees that in the making of this Application, it is acting for and on behalf of itself and as the agent representative of its Eligible Students and their Dependents, if any; and it is agreed and understood that the Academic Institution is not the agent or representative of CareFirst/CareFirst BlueChoice for any purpose of this Application or any Academic Institution Contract issued pursuant to this Application.

The Academic Institution agrees to receive on behalf of its Eligible Students and their Dependents, the Individual Enrollment Agreement including all attachments, and all relevant notices furnished by CareFirst/CareFirst BlueChoice, and to forward such materials to these individuals.

The Academic Institution agrees that in the making of this Application, it has provided CareFirst/CareFirst BlueChoice with information regarding the eligibility of enrollees that is accurate and

consistent with the requirements and provisions of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (as amended and codified).

This Academic Institution Contract Application is part of the Agreement between the Academic Institution and CareFirst/CareFirst BlueChoice.

IMPORTANT NOTE: The Academic Institution's rate sheet, which describes the benefits and corresponding rates for CareFirst coverage selected must be signed by the Academic Institution before coverage can be made effective. CareFirst reserves the right to revise the rates if the actual enrollment varies substantially from that used in the original rating or if applicable law or regulatory authority requires such revisions.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If the Academic Institution has any questions concerning the benefits and services that are provided by or excluded under the coverage for which the Academic Institution is applying, please contact a customer services representative before signing this Application.

ACCEPTED FOR:

_____
(Name of Organization)

BY: _____
(Printed Name of Authorized Officer)

_____
([Electronic] Signature of Authorized Officer)

Title:_____ Date: _____

Broker (if applicable)

_____
(Printed Name of Broker)

_____
(Signature of Broker)

Email Address: _____

Broker ID#: _____ Date: _____

Effective Date of Academic Institution Contract: _____

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
(202) 479-8000

An independent licensee of the BlueCross and Blue Shield Association

STUDENT HEALTH PLAN
IN-NETWORK ACADEMIC INSTITUTION CONTRACT

The consideration for this Academic Institution (Institution of Higher Education) Contract is: (1) the Academic Institution Contract Application; (2) the payment of Premiums when they are due, and (3) the fulfillment of the Academic Institution's obligations, set forth herein. CareFirst BlueChoice agrees to provide the benefits described in this Academic Institution Contract for a period of twelve (12) months beginning on the Effective Date stated in the Contract Application and from year to year after that, unless the Academic Institution Contract is amended or terminated in accordance with the terms of this Academic Institution Contract.

Academic Institution Name: _____

Academic Institution Number: _____

Product Name: _____

Effective Date: _____

CareFirst BlueChoice, Inc.

[Signature]

_____

[Name]
[Title]

These provisions govern the relationship between the Academic Institution (Institution of Higher Education) and CareFirst BlueChoice. As such, they may not be contained in the benefit guides that are provided for the use of Members.

I. Entire Contract. The entire contract between the Academic Institution and CareFirst BlueChoice consists of this Academic Institution Contract (aka the "School Contract"), the Student Health Plan Contract Application, the rate quote packet, the Student Health Plan Individual Enrollment Agreement and all duly authorized attachments referred to therein, and any duly authorized riders, endorsements, and amendments attached to this School Contract or to the Student Health Plan Individual Enrollment Agreement.

II. Definitions. In addition to the definitions contained in the Student Health Plan Individual Enrollment Agreement, the underlined terms, when capitalized in this School Contract, are defined as follows:

Academic Institution means the Institution of Higher Education named on the Contract Application and to which CareFirst BlueChoice has issued the School Contract.

Academic Institution or School Contract means this Student Health Plan Contract.

Academic Institution Contract Application means the Academic Institution Contract Application submitted by the Academic Institution to CareFirst BlueChoice pursuant to which CareFirst BlueChoice has issued this School Contract. The Contract Application is a part of this Academic Institution Contract.

Benefit Materials means (i) any enrollment or other coverage information or materials provided by CareFirst BlueChoice to the Academic Institution for delivery to Eligible Persons, (ii) Student Health Plan Individual Enrollment Agreement, and (iii) any benefit summaries or other notices or materials relating to the Student Health Plan Individual Enrollment Agreement required by federal or state law or regulation to be provided by the Academic Institution or CareFirst BlueChoice to Eligible Persons.

Blue Cross and Blue Shield Association means the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Contract Year means 365 days from the effective date of the Agreement each year.

Eligible Person means a person identified in the Student Health Plan Individual Enrollment Agreement as eligible to enroll including, but not limited to: (i) Eligible Students and (ii) their eligible Dependents, if the Academic Institution has elected to offer coverage for Dependents.

Eligible Student means an individual eligible under the guidelines defined by the Academic Institution sponsoring this Agreement who is an admitted or continuing candidate in a recognized degree or certificate program sponsored by the Academic Institution.

Member means a person who meets all applicable eligibility requirements, who is enrolled either as a Subscriber or a Dependent, if the Academic Institution has elected to offer coverage for Dependents and for whom the Premiums have been received by CareFirst BlueChoice.

Premium means the dollar amounts the Academic Institution remits on behalf of the Member for benefits offered under the Academic Institution Contract.

Rescind or Rescission means a termination, cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual's or group's enrollment is a Rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a Rescission. Coverage is not Rescinded and a cancellation or discontinuance of coverage is not a Rescission if:

A. The termination, cancellation or discontinuance of coverage only has a prospective effect; or

B. The termination, cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due by the Academic Institution.

Student Health Plan Individual Enrollment Agreement means the Student Health Plan Individual Enrollment Agreement issued to the Subscribers and attached to this Academic Institution Contract, including all duly authorized attachments, amendments, and riders.

Subscriber means a Member who is enrolled under the Student Health Plan Individual Enrollment Agreement as an Eligible Student of the Academic Institution, rather than as a Dependent.

III. Enrollment Requirements. Eligible Students and their Dependents, if the Academic Institution has elected to offer coverage for Dependents, are those persons who meet the criteria shown in the Student Health Plan Individual Enrollment Agreement, except as otherwise shown in the Academic Institution Enrollment Application.

A The composition of the Academic Institution, the Academic Institution's eligibility requirements, and the structure of the Academic Institution's benefit offerings to potential Members, that are stated in this Academic Institution Contract or in the Contract Application are material to the execution of this Academic Institution Contract by CareFirst BlueChoice.

B. CareFirst BlueChoice reserves the right to inspect the records of the Academic Institution in order to verify the eligibility of Eligible Students and their Dependents, if the Academic Institution has elected to offer coverage for Dependents, In addition, the Academic Institution may be required by CareFirst BlueChoice to complete and return to CareFirst BlueChoice an eligibility audit and/or census report annually.

IV. Academic Institution Cooperation – Benefit Materials.

A. The Academic Institution shall: (1) deliver to Eligible Persons all Benefit Materials within the timeframes and in the manner specified by law or regulation, and/or as instructed by CareFirst BlueChoice; and (2) allow CareFirst BlueChoice reasonable access to the Academic Institution's Eligible Students and other eligible persons for purposes of enrollment. The Academic Institution shall promptly provide any information requested by CareFirst BlueChoice to prepare any Benefit Materials.

B. The Academic Institution shall maintain a record of its distribution of Benefit Materials to Eligible Persons. The Academic Institution shall provide such records to CareFirst BlueChoice within fifteen (15) days of request.

C. The Academic Institution shall indemnify, defend, and hold harmless CareFirst BlueChoice from all claims, damages, losses and liabilities, including reasonable attorney's fees, arising out of any failure by the Academic Institution to provide any Benefit Materials to Eligible Persons within the timeframes specified by law or regulation and/or as instructed by CareFirst BlueChoice.

D. Unless CareFirst BlueChoice makes delivery directly to the covered person or member, CareFirst BlueChoice will provide to the Academic Institution, for delivery to each covered person or member, a statement that summarizes the essential features of the insurance coverage of the covered person or member and that indicates to whom benefits under the policy are payable; and if Dependents are included in the coverage. Only one statement need be issued for each family unit.

V. Academic Institution Responsibilities and Administration.

A. All Premiums shall be paid to CareFirst BlueChoice by the Academic Institution. In any case in which the Eligible Person will be responsible for a portion of the monthly Premiums upon enrollment, the Academic Institution shall make the appropriate payment arrangements, if applicable, for enrolled Members.

B. In the event CareFirst BlueChoice refunds to the Academic Institution a Premium, or a portion of a Premium, attributed to the enrollment or termination of a Subscriber or his or her Dependents, if the Academic Institution has elected to offer coverage for Dependents,, the Academic Institution agrees to pay, credit or allocate the Subscriber's contributed share of the refunded Premium to the Subscriber.

C. The Academic Institution agrees to furnish CareFirst BlueChoice on a monthly basis, and on CareFirst BlueChoice's approved forms, such information as may reasonably be required by CareFirst BlueChoice for the administration of the coverage provided under this Academic Institution Contract.

D. The Academic Institution will provide to all Eligible Persons any and all electronic or paper Summaries of Benefits and Coverage (SBCs) and Student Health Plan Individual Enrollment Agreements and all duly authorized attachments (Agreements) or other notices and/or materials provided by CareFirst BlueChoice. Upon specific request by a Member, CareFirst BlueChoice will also provide such information directly to such Member.

E. The Academic Institution shall furnish CareFirst BlueChoice with all enrollment information necessary to calculate Premiums or any other payments due under the Academic Institution Contract. This required information to be provided to CareFirst BlueChoice includes new enrollment information, new Dependents, if the Academic Institution has elected to offer coverage for Dependents, as well as information regarding terminations of Subscribers and/or Dependents. Clerical errors or delays by the Academic Institution when providing such information to CareFirst BlueChoice will not invalidate coverage which would otherwise be in effect. Upon discovery of any errors or delays, an equitable adjustment of charges and benefits will be made.

F. The Academic Institution shall notify CareFirst BlueChoice, no later than the end of the election period, when a Member has elected to continue coverage under state or federal law or regulation.

G. In addition, CareFirst BlueChoice may at reasonable times examine the Academic Institution's pertinent records (including payment records) with respect to eligibility and Premium payments under this Academic Institution Contract. CareFirst BlueChoice may establish reasonable requirements of proof to confirm the eligibility of Members. The Academic Institution shall provide, within thirty-one (31) days of request, any information that verifies its compliance with the enrollment guidelines.

VI. Academic Institution's Responsibility to Eligible Students. All Premiums shall be paid to CareFirst BlueChoice by the Academic Institution. In any case in which the Eligible Student will be responsible for a portion of the monthly Premiums upon enrollment, the Academic Institution must:

A. Advise the Eligible Student of his/her eligibility for coverage under the Academic Institution Contract;

B. Advise the Eligible Student when he or she may enroll for such coverage in accordance with the provisions stipulated in the Academic Institution Contract Application or the Academic Institution Contract.

C. Advise the Eligible Student when coverage will commence based on the aforementioned provisions and the date of completion of the enrollment form;

D. Advise the Eligible Student of the cost of such coverage to the Eligible Student and the method in which payment is to be made; and

E. Obtain from the Eligible Student a completed enrollment form and a signed agreement by the Eligible Student to pay the applicable portion of the monthly Premium.

VII. Member Effective Dates.

A. Coverage for Eligible Persons enrolled under the Student Health Plan Individual Enrollment Agreement becomes effective on the date stated in the Student Health Plan Individual Enrollment Agreement. The Benefit Period for Eligible Persons enrolled under the Student Health Plan Individual Enrollment Agreement shall be on a Contract Year basis.

B. Waiver of Coverage. Coverage for Eligible Students automatically enrolled by the Academic Institution under the Student Health Plan Individual Enrollment Agreement becomes effective on the date stated in the Student Health Plan Individual Enrollment Agreement. While students who are automatically enrolled by the Academic Institution may drop their coverage during the open enrollment process; they may not drop coverage if any claims have been incurred.

VIII. Payment Provisions.

A. Premiums. All Premiums shall be paid to CareFirst by the Academic Institution. The Academic Institution must pay the full Premium due within the Contract Year. Payment may be made in monthly installments, in one lump sum or two installments (the "Premium Due Date").

1. If the Academic Institution elects to pay monthly, the Premium payments are due the first day of the month. The initial Premium payment is due on the [thirtieth (30th)] day after completion of the student waiver period but no later than [October 31, [2020]]; or

2. If the Academic Institution elects to make one lump sum payment for the entire Contract Year, the Premium is due on the [thirtieth (30th)] day after completion of the student waiver period but no later than [October 31, [2020]]; or

3. If the Academic Institution elects to make two payments within the Contract Year, the initial Premium payment for coverage is due on the [thirtieth (30th)] day after completion of the student waiver period but no later than [October 31, [2020]], and the second payment is due on or before [January 1, [2021]].

4. If the Academic Institution elects to pay Premiums through an electronic payment, CareFirst may not debit or charge the amount of the Premium due prior to the Premium Due Date, except as authorized by the Academic Institution.

For purposes of this provision, student waiver period means that period of time between the start of the Contract Year and the date set by the Academic Institution for Eligible Students to decline coverage under this plan.

A. Grace Period. Except for the initial premium(s), there is a grace period beginning on the Premium Due Date within which overdue premiums can be paid without loss of coverage.

1. A grace period of thirty-one (31) days beginning on the Premium Due Date will be granted for payment of each premium due subsequent to payment of the first premium. No grace period shall apply if CareFirst BlueChoice does not intend to renew the Academic Institution Contract beyond the period for which premiums have been accepted and notice of the intention not to renew is delivered to the Academic Institution at least forty-five (45) days before the premium is due. During the grace period the Academic Institution Contract shall continue in force.

2. Unless CareFirst BlueChoice receives a notice of the Academic Institution's intention to terminate the Academic Institution Contract before the end of the grace period, CareFirst BlueChoice will collect the premium for the thirty-one (31)-day grace period.

3. If CareFirst BlueChoice receives a notice of the intention to terminate the Academic Institution Contract during the grace period, CareFirst BlueChoice will collect the premium for the period beginning on the first day of the grace period until the date on which notice is received, or the date of termination stated in the notice, whichever is later.

4. If the premium for the thirty-one (31)-day grace period is paid after the grace period ends, CareFirst BlueChoice may charge interest for the premium, but interest may not begin to accrue during the thirty-one (31)-day grace period, and the interest rate charged will not exceed an effective rate of six (6) percent per year.

5. Non-Payment of Premiums. If premiums are not received by the Academic Institution by the Premium Due Date and CareFirst BlueChoice does not receive a notice of the Academic Institution's intention to terminate the Academic Institution Contract, CareFirst BlueChoice will notify the Academic Institution in writing of the overdue premiums. If CareFirst BlueChoice receives payment of all amounts listed on the notice from the Academic Institution prior to the end of the grace period, coverage will continue without interruption. If CareFirst BlueChoice does not receive full payment from the Academic Institution prior to the end of the grace period, CareFirst BlueChoice will, upon notice to the Academic Institution, terminate the Academic Institution Contract, effective as of 11:59 p.m. Eastern Time on the last day of the grace period. Members will be liable for the cost of any benefit provided or paid by CareFirst BlueChoice for services received after the effective date of termination subject to the extension of benefits provision. The Academic Institution will be liable for all premiums or other outstanding charges incurred up to and including the date of termination.

B. Payment of all Premiums is a condition precedent to the performance of CareFirst BlueChoice's duties and obligations hereunder. The Academic Institution will remit a Premium for each Member under the terms of this Group Contract.

C. Premium Adjustments. All Premium adjustments for Members enrolling or terminating during the term of this Academic Institution Contract shall be calculated based upon the billing method established between the Academic Institution and CareFirst BlueChoice.

D. Retroactive Termination of Members. When the Academic Institution fails to provide prospective notice of a Member's termination, CareFirst BlueChoice will only retroactively terminate a Member's coverage at 11:59 p.m., Eastern Time, as follows:

1. If termination occurs during the first six (6) months of the Benefit Period, coverage will end at the end of the first six (6) months of Benefit Period.

2. If termination occurs during the second six (6) months of the Benefit Period, coverage will continue until the end of the Benefit Period.

If an earlier termination date is requested by the Subscriber, Premiums will be refunded on a pro-rata basis, as applicable. The Subscriber is required to notify the Academic Institution of termination under Section 4.1C.3 of the Individual Enrollment Agreement, and the Academic Institution is required to issue any applicable refund.

The Academic Institution agrees to indemnify and hold harmless CareFirst BlueChoice, its subsidiaries, officers, employees, agents and contractors from any and all claims, actions, damages, liabilities, and expenses whatsoever (including reasonable attorney fees) incurred or for which liability for the payment of has been determined, as a result of any act or omission on the part of the Academic Institution or its subsidiaries, officers, employees, agents and contractors in connection with or related to any failure to comply with any provisions of law, regulation or administrative directive, relating to or concerning the providing of timely and adequate certificates of creditable coverage and as the same is more fully addressed and set forth under the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any future amendments thereto.

E. Premium Rate Changes. CareFirst BlueChoice will not increase the Academic Institution's Premium rate during the 12-month period beginning on the effective date of this Academic Institution Contract. CareFirst BlueChoice may increase the Academic Institution's Premium more frequently if the increase is due solely to the enrollment of new Members.

CareFirst BlueChoice will provide notice of a change to Premium rates by giving the Academic Institution at least forty-five (45) days prior written notice. CareFirst BlueChoice will also prominently post notice of the Premium change and justification for such on the CareFirst BlueChoice website.

F. Reconciliation Process. Academic Institution agrees to a monthly reconciliation process during which Member enrollment and Premiums received will be reviewed by CareFirst BlueChoice, including any special enrollments that may occur during the Contract Year. In the event that CareFirst BlueChoice identifies a Premium under-payment as a result of this reconciliation, the Academic Institution shall promptly remit the amount owed to CareFirst BlueChoice.

IX. Misstatement of Age. If the benefits or Premium set out in this Academic Institution Contract vary based on the Member's age, and if the age of a Member is misstated by the Subscriber, eligible Dependent, if the Academic Institution has elected to offer coverage for Dependents,, or Academic Institution, an equitable adjustment of the benefits or Premium will be made by CareFirst BlueChoice. Any benefit determinations or Premium charges made based on the Member's misstated age will be adjusted by CareFirst BlueChoice as soon as reasonably possible by recalculating the benefit or Premium using the correct age, and written notification will be sent to the Member by the Academic Institution.

X. Uniform Modification and Amendment Procedure.

A. Uniform Modification. CareFirst BlueChoice reserves the right to modify the Student Health Plan Individual Enrollment Agreement at renewal.

B. Amendment Procedure. Amendments must be consistent with state law. CareFirst BlueChoice may amend the Academic Institution Contract with respect to any matter, including premium rates, by mailing or, if consent has been given, by e-mailing to the Academic Institution's last known e-mail address a notice, including any amendment(s), where applicable, to the Academic Institution at its address of record with CareFirst BlueChoice at least forty-five (45) days before the amendment(s) are to take effect.

1. All such amendments are deemed accepted by the Academic Institution unless the Academic Institution gives CareFirst BlueChoice written notice of non-acceptance within fifteen (15) days following the notice date, in which event the Academic Institution may cancel the Academic Institution Contract effective as of the renewal date, upon written notice to CareFirst BlueChoice. If state or federal law mandates an amendment, it will be automatically deemed accepted by the Academic Institution.

2. Regardless of when the amendment is received, the Student Health Plan Individual Enrollment Agreement and this Academic Institution Contract are considered to be automatically amended of the date specified in the contract amendment or the notice (if not stated in the contract amendment), unless otherwise mandated, to conform with any applicable changes to state or federal law.

3. No agent or other person, except an officer of CareFirst BlueChoice, has authority to waive any conditions or restrictions of the Academic Institution Contract, or to extend the time for making payments hereunder, or to bind CareFirst BlueChoice by making any promise or representation or by giving or receiving any information. No change in the Academic Institution Contract will be binding on CareFirst BlueChoice, unless evidenced by an amendment signed by an authorized representative of CareFirst BlueChoice.

XI. Contract Renewal. CareFirst BlueChoice will send notice of the renewal of this Academic Institution Contract no later than forty-five (45) days prior to the Contract Renewal Date, except as outlined in the Termination or Rescission of Academic Institution Contract provision below.

XII. Termination or Rescission of Academic Institution Contract. The Academic Institution Contract may be terminated as follows:

A. The Academic Institution may terminate the Academic Institution Contract at any time. Such termination shall be effective at midnight on the termination date specified by the Academic Institution. The Academic Institution will be responsible for providing a notice to each Member.

B. CareFirst BlueChoice may terminate the Academic Institution Contract for one of the following reasons:

1. Failure of the Academic Institution to pay Premiums or any other payment due under the terms of the Academic Institution Contract.

2. The Academic Institution has failed to comply with a material plan provision in the Academic Institution Contract relating to participation rules, in which case, CareFirst BlueChoice will provide the Academic Institution forty-five (45) days' notice prior to termination.

3. CareFirst BlueChoice elects not to renew all student health insurance coverage in the state. In this case, CareFirst BlueChoice will provide notice of the nonrenewal at least one hundred eighty (180) days before the date of the nonrenewal to the affected individuals and Academic Institution, give notice to the District of Columbia Department of Insurance, Securities and Banking at least thirty (30) working days before the notice referred to above, not sell new business for groups in the District of Columbia for a five (5) year period beginning with the date of such notice to the Commissioner, and act uniformly without regard to the claims experience of any affected Academic Institution, or any Health Status-Related factor of any affected individual.

C. Rescission of an Academic Institution Contract. CareFirst BlueChoice may Rescind this Academic Institution Contract for one of the following reasons:

1. The Academic Institution has performed an act, practice, or omission that constitutes fraud; or

2. The Academic Institution has made an intentional misrepresentation of material fact under the terms of coverage.

In case of Rescission, CareFirst BlueChoice will provide thirty (30) days advance written notice of any Rescission to each Subscriber who would be affected by the Rescission. This Academic Institution Contract will be terminated effective on the date on which CareFirst BlueChoice determines that the act, practice, or omission that constitutes fraud or the intentional misrepresentation material fact (a) occurred, or (b) was relied upon by CareFirst BlueChoice, whichever is earlier.

This Academic Institution Contract may not be Rescinded in the absence of fraud or an intentional misrepresentation of material fact and without thirty (30) days advance written notice.

D. The Academic Institution will be liable for all Premiums and other outstanding charges up to and including the date of termination. The Academic Institution and/or Members will be liable for the cost of any services provided or paid by CareFirst BlueChoice for services received on or after the date of termination except as provided in the Student Health Plan Individual Enrollment Agreement.

XIII. Insolvency. In the event of insolvency, CareFirst BlueChoice's rights under the Academic Institution Contract (including, but not limited to, all rights to Premiums to the extent permitted by applicable bankruptcy law) shall become vested in any person or entity that guarantees payment and actually pays for the services and benefits that CareFirst BlueChoice is obligated to make available under the Academic Institution Contract.

XIV. Contestability of Coverage. This Academic Institution Contract may not be contested, except for nonpayment of Premiums, after it has been in force for two (2) years from its date of issue. Any rescission of coverage of the Academic Institution or of any Member shall only be based upon an act, practice or omission that constitutes fraud or is due to an intentional misrepresentation of material fact. Absent fraud, each statement made by an applicant, Academic Institution, or Member is considered to be a representation and not a warranty. A statement made to effectuate coverage may not be used to avoid the coverage or reduce benefits under this Academic Institution Contract unless the statement is contained in a written instrument signed by the Academic Institution or Member, and a copy of the statement is given to the Academic Institution or Member. CareFirst BlueChoice shall give thirty (30) days advance written notice of any rescission of coverage of the Academic Institution or any Member. This provision does not preclude the assertion at any time of defenses to any claim based upon the person's ineligibility for coverage under this Academic Institution Contract or upon other provisions in this Academic Institution Contract.

XV. Blue Cross and Blue Shield Association Plan Disclosure. The Academic Institution, on behalf of itself and its Members, hereby expressly acknowledges its understanding that this Academic Institution Contract constitutes a contract solely between the Academic Institution and CareFirst BlueChoice; that CareFirst BlueChoice is an independent corporation operating under a license from the Blue Cross and Blue Shield Association permitting CareFirst BlueChoice to use the Blue Cross and Blue Shield Service Marks in the District of Columbia, Maryland, and portions of Virginia; and that CareFirst BlueChoice is not contracting as the agent of the Blue Cross and Blue Shield Association. The Academic Institution, on behalf of itself and its Members, further acknowledges and agrees that it has not entered into this Academic Institution Contract based upon representations by any person other than CareFirst BlueChoice; and no person, entity, or organization other than CareFirst BlueChoice shall be held accountable or liable to the Academic

Institution for any of CareFirst BlueChoice's obligations to the Academic Institution created under this Academic Institution Contract. This paragraph shall not create any additional obligations whatsoever on the part of CareFirst BlueChoice other than those obligations created under other provisions of this Academic Institution Contract.

XVI. Prohibition Against Discrimination.

A. General. CareFirst BlueChoice will not discriminate for any purpose, including but not limited to, enrollment, eligibility, variations in Premium rates, and/or coverage under the terms of the Student Health Plan Individual Enrollment Agreement, on the basis of race, color, sex, sexual orientation, gender expression, gender identity, religion, disability, age, veteran status, ancestry, or national or ethnic origin.

B. Highly-Compensated Individuals. The Academic Institution hereby expressly acknowledges its obligation and responsibility to comply with the non-discrimination requirements of Section 2716 of the Public Health Service Act, which prohibits discrimination in favor of highly compensated individuals.

The Academic Institution agrees to indemnify, defend, and hold harmless CareFirst BlueChoice and its officers, directors, agents, employees, and affiliates from all demands, claims, damages to persons or property, losses, liabilities, or expenses, including reasonable attorney's fees, arising out of or caused by any failure by the Academic Institution to comply with the obligations and responsibilities stated in this section, in the manner required by law.

C. Health Status. CareFirst BlueChoice will not discriminate against any Member for purposes including, but not limited to, eligibility, enrollment, variations in Premium rates, and/or coverage under the terms of the Student Health Plan Individual Enrollment Agreement, based on health status, medical condition (including both, mental and physical illness), claims experience, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

D. Premium Subsidies. CareFirst BlueChoice will not discriminate against or in favor of any individual eligible to enroll under the Student Health Plan Individual Enrollment Agreement for purposes including, but not limited to, eligibility, enrollment, variations in Premium rates, and/or coverage under the terms of the Student Health Plan Individual Enrollment Agreement, on the basis of such individual's eligibility for, or receipt of federal premium subsidies.

XVII. Notices.

A. Notices to Subscribers required under this Academic Institution Contract shall be in writing directed either to the Subscriber's last known address or, if consent has been given, by e-mail to the Subscriber's last known e-mail address. It is the Subscriber's responsibility to notify the Academic Institution, and the Academic Institution's responsibility to notify CareFirst BlueChoice of an address or e-mail address change. The notice will be effective on the date mailed or sent by e-mail, whether or not the Member in fact receives the notice or there is a delay in receiving the notice.

B. Notices to the Academic Institution will be sent either by first class mail to the address set forth in the Contract Application or, if consent has been given, by e-mail to the Academic Institution's e-mail address. Notice will be effective on the date of receipt by the Academic Institution, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service.

1. The Academic Institution may change the address or, in the manner specified in the Academic Institution's consent to receive electronic notices, the Academic

Institution's e-mail address at which notice is to be given by providing written notice thereof to CareFirst BlueChoice.

2. If the Academic Institution is a brokered account, notices to the Academic Institution required or arising under the Academic Institution Contract will be effectively given by CareFirst BlueChoice by sending such notice directly to the Academic Institution as set forth above or, alternatively, by providing notice in the manner described above to the Academic Institution's current broker of record as recognized and listed in CareFirst BlueChoice's records. The Academic Institution will promptly notify CareFirst BlueChoice of any change in the designated broker under the Academic Institution Contract.

C. Except with regard to the Academic Institution's consent to receive electronic notices, when notice is sent to CareFirst BlueChoice, it must be sent by first class mail to:

CareFirst BlueChoice BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

Notice will be effective on the date of receipt by CareFirst BlueChoice, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service. CareFirst BlueChoice may change the address at which notice is to be given by providing written notice to the Academic Institution.

D. CareFirst BlueChoice will notify the Academic Institution in writing of any changes that may result in a reduction of benefits no less than ninety (90) days before the date on which the change will become effective.

XVIII. Electronic Notices. If the Academic Institution has agreed to receive electronic notices:

A. CareFirst BlueChoice may send the following notices and documents electronically to the Academic Institution:

1. Communications required by this Academic Institution Contract, the Student Health Plan Individual Enrollment Agreement, or federal or state law.

2. Communications relating to the products or services the Academic Institution receives from CareFirst BlueChoice, including but not limited to enrollment, wellness program information and notices (including disease management and wellness preventive information), and similar notices.

3. Information on new or additional products, services, or programs offered by CareFirst BlueChoice.

B. The Academic Institution may revoke its consent to receive the electronic notices at any time.

C. The Academic Institution can change its consent elections or its email address online, at any time.

D. The Academic Institution may obtain a paper copy of any electronically furnished notice or document free of charge.

E. In order to access information provided electronically, the Academic Institution must have the following:

1. A computer with Internet access

2. An email account that allows the Academic Institution to send and receive emails

3. Internet Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

XIX. Amendments and Modifications. No amendment or modification of any term or provision is valid until approved by an executive officer of CareFirst BlueChoice and unless the approval is endorsed on the policy and attached to the Student Health Plan Individual Enrollment Agreement or Academic Institution Contract. No other person has authority to change this Student Health Plan Individual Enrollment Agreement or Academic Institution Contract or waive any of its provisions.

Oral statements cannot be relied upon to modify or otherwise affect the benefits, limitations, and/or exclusions of this Academic Institution Contract or the Student Health Plan Individual Enrollment Agreement, or to increase or void any coverage or reduce any benefits under this Academic Institution Contract or the Student Health Plan Individual Enrollment Agreement. Such oral statements cannot be used in the prosecution or defense of a claim under this Academic Institution Contract or the Student Health Plan Individual Enrollment Agreement.

XX. Academic Institution Statement. The Academic Institution agrees that in the making of this Academic Institution Contract, it is acting for and on behalf of itself and as the agent representative of its Eligible Persons; and it is agreed and understood that the Academic Institution is not the agent or representative of CareFirst BlueChoice for any purpose of this Academic Institution Contract.

XXI. Assignment. The Academic Institution Contract is not assignable by the Academic Institution without the written consent of CareFirst BlueChoice.

IMPORTANT NOTE: The Academic Institution's rate sheet which describes the benefits and corresponding rates for the coverage selected must be signed by the Academic Institution before coverage can be made effective. CareFirst BlueChoice reserves the right to revise the rates if the actual enrollment varies substantially from that used in the original rating or if applicable law or regulatory authority requires such revisions.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ACCEPTED FOR:

_____
(Name of Academic Institution)

BY: _____
(Printed Name of Authorized Officer)

_____
(Signature of Authorized Officer)

Title: _____

Date: _____

CareFirst BlueChoice, Inc.

[840 First Street, NE]
[Washington, DC
20065]
[202-479-8000]

An independent licensee of the Blue Cross and Blue Shield Association

IN-NETWORK STUDENT HEALTH PLAN
INDIVIDUAL ENROLLMENT AGREEMENT

This is the In-Network Agreement for the jointly offered Point-of-Service product with In-Network HMO benefits administered by CareFirst BlueChoice, Inc. and Out-of-Network indemnity benefits administered by Group Hospitalization and Medical Services, Inc., doing business as, CareFirst BlueCross BlueShield (CareFirst). Each time that services are sought, the Member may choose to receive In-Network HMO benefits or Out-of-Network indemnity benefits.

This In-Network Agreement, including any duly authorized attachments, notices, amendments, and riders, is a part of the Academic Institution Contract issued to the Subscriber and contains the principal provisions affecting the Member(s) Academic Institution (Institution of Higher Education) through which Subscribers are enrolled under the In-Network Agreement and other provisions that explain the duties of CareFirst BlueChoice and those of the Subscriber or Application Filer.

The Academic Institution accepts and agrees to the In-Network Agreement and the Out-of-Network Academic Institution Contract by making payment of the initial Premium to CareFirst BlueChoice. CareFirst BlueChoice agrees to the In-Network Academic Institution Contract when it is issued to the Subscriber.

CareFirst BlueChoice may, under certain circumstances, discontinue coverage of a Member or terminate this In-Network Agreement. See Section 4 of the In-Network Agreement for additional information.

NOTE: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition CareFirst BlueChoice may deny insurance benefits if false information materially related to a claim was provided by the applicant.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE: In the event the Subscriber needs to contact someone about this insurance for any reason, the Subscriber should contact their agent. If no agent was involved in the sale of this insurance, or if the Subscriber has additional questions, the Subscriber may contact the insurance company issuing this insurance at the following address: 840 First Street, NE, Washington, DC 20065, and telephone number: 202-479-8000. Written correspondence is preferable so that a record of the Subscriber's inquiry is maintained. When contacting the agent, company or the Bureau of Insurance, the Subscriber should have their policy number available.

CareFirst BlueChoice recommends that the Subscriber familiarizes himself or herself with the CareFirst BlueChoice complaint and appeal procedure and make use of it before taking any other action.

[Subscriber Name: _____]

[Subscriber ID Number: _____]

[Product Name: _____]

[Effective Date: _____]

Term: This Agreement will have an initial term from the Agreement Effective Date stated above until the last day of the Academic Institution Contract year. This Agreement is a conditionally renewable plan.

CareFirst BlueChoice, Inc.

[Signature]

_____

[Name]
[Title]

SECTION 1
DEFINITIONS

The underlined terms when capitalized are defined as follows:

Academic Institution means the organization to which CareFirst BlueChoice has issued an Academic Institution Contract pursuant to which Eligible Students and their Dependents, to the extent such dependents are covered under this Agreement, are enrolled for covered health benefits. as set forth herein.

Academic Institution Contract means the contract, including all duly authorized attachments, notices, amendments and riders, between CareFirst and the Academic Institution.

Adoption means the earlier of a judicial decree of adoption or, the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.

Adult means an individual eighteen (18) years old or older.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152).

Agreement means this policy, which includes all attachments, amendments and riders, if any, between the Academic Institution and CareFirst BlueChoice (also referred to as the Academic Institution Contract).

Allowed Benefit means:

A. For a Contracting Provider, the Allowed Benefit for a Covered Service is the lesser of:

1. The provider's actual charge which, in some cases, will be a rate set by a regulatory agency; or

2. The benefit amount, according to the CareFirst BlueChoice rate schedule, for the Covered Service that applies on the date that the service is rendered.

B. For Emergency Services provided by a Non-Contracting Provider, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge, or the amount that would be paid to a Contracting Provider for the Covered Service; in no event shall the Allowed Benefit be less than the amount allowed by Medicare. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the practitioner's actual charge. The provider may bill the Member directly for such amounts.

. The Member is responsible for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits.

Pediatric Dental Allowed Benefit means:

For Preferred Dentists, the Pediatric Dental Allowed Benefit payable to a Preferred Dentist for a Covered Dental Service will be the amount agreed upon between the Dental Plan and the Preferred Dentist. The Pediatric Dental Allowed Benefit is accepted by the Preferred Dentist as payment in full, except for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits.

Prescription Drug Allowed Benefit means the lesser of:

A. The Pharmacy's actual charge; or

B. The benefit amount, according to the CareFirst BlueChoice fee schedule, for covered Prescription Drugs that applies on the date the service is rendered.

If the Member purchases a covered Prescription Drug or diabetic supply from a Contracting Pharmacy Provider, the benefit payment is made directly to the Contracting Pharmacy Provider and is accepted as payment in full, except for any applicable Deductible, Copayment, or Coinsurance. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance and the Contracting Pharmacy Provider may bill the Member directly for such amounts.

If the Member purchases a covered Prescription Drug from a Non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst or its designee in the amount of the Allowed Benefit, minus any applicable Deductible, Copayment, or Coinsurance. Members may be responsible for balances above the Allowed Benefit.

Pediatric Vision Allowed Benefit means:

A. For a Contracting Vision Provider, the Pediatric Vision Allowed Benefit for a covered service is the lesser of:

1. The actual charge; or

2. The benefit amount, according to the Vision Care Designee's rate schedule for the covered service or supply that applies on the date the service isrendered.

The benefit payment is made directly to a Contracting Vision Provider. When a Member receives Covered Vision Services from a Contracting Vision Provider, the benefit payment is accepted as payment in full, except for any applicable Copayment. When a Member receives frames and spectacle lenses or contact lenses from a Contracting Vision Provider, the benefit payment is as stated in the Schedule of Benefits below. The Contracting Vision Provider may collect any applicable Copayment or amounts in excess of the Vision Care Designee's payment when other frames and nonstandard spectacle lenses or other contact lenses are purchased by the Member.

B. For a Non-Contracting Vision Provider, the Allowed Benefit for Vision Care will be determined in the same manner as the Allowed Benefit to a Contracting Vision Provider.

Benefits may be paid to the Subscriber or to the Non-Contracting Vision Provider at the discretion of the Vision Care Designee. The Member is responsible for the cost difference between the Vision Care Designee's payment and the Non-Contracting Vision Provider's actual charge. The Non-Contracting Vision Provider may bill the Member directly. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Contracting Vision Provider.

Vision Allowed Benefit means:

A. For a Contracting Vision Provider, the Vision Allowed Benefit for a covered service is the lesser of:

1. The actual charge; or

2. The benefit amount, according to the Vision Care Designee's rate schedule for the covered service or supply that applies on the date the service isrendered.

The benefit payment is made directly to a Contracting Vision Provider. When a Member receives Covered Vision Services from a Contracting Vision Provider, the benefit payment is accepted as payment in full, except for any applicable Copayment. When a Member receives frames and spectacle lenses or contact lenses from a Contracting Vision Provider, the benefit payment is as stated in the Schedule of Benefits below. The

Contracting Vision Provider may collect any applicable Copayment or amounts in excess of the Vision Care Designee's payment when other frames and non-standard spectacle lenses or other contact lenses are purchased by the Member.

B. For a Non-Contracting Vision Provider, the Allowed Benefit for Vision Care will be determined in the same manner as the Allowed Benefit to a Contracting Vision Provider.

Benefits may be paid to the Subscriber or to the Non-Contracting Vision Provider at the discretion of the Vision Care Designee. The Member is responsible for the cost difference between the Vision Care Designee's payment and the Non- Contracting Vision Provider's actual charge. The Non-Contracting Vision Provider may bill the Member directly. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Contracting Vision Provider.

Annual Open Enrollment Period means the periods during each Contract Year during which an eligible individual may enroll or change coverage under this Agreement.

Benefit Period means the Contract Year during which coverage is provided for Covered Services, Covered Dental Services and Covered Vision Services.

Bereavement Counseling means counseling provided to the Immediate Family or Family Caregiver of the Member after the Member's death to help the Immediate Family or Family Caregiver cope with the death of the Member.

Body Mass Index (BMI) means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand Name Drug means a Prescription Drug that has been given a name by a manufacturer or distributor to distinguish it as produced or sold by a specific manufacturer or distributor and that may be used and protected by a trademark.

Cardiac Rehabilitation means inpatient or outpatient services designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse atherosclerotic process and enhance the psychosocial and vocational status of eligible Members.

CareFirst BlueCross BlueShield (CareFirst) means the business name of Group Hospitalization and Medical Services, Inc. (GHMSI)

Caregiver means a person who is not a health care provider, who lives with or is the primary Caregiver of the terminally-ill Member in the home. The Caregiver can be a relative by blood, marriage, or Adoption (see Family Caregiver definition), or a friend of the Member, but cannot be a person who normally charges for providing services. However, at CareFirst's discretion, a Caregiver may be an employee of a hospice care hospital/agency.

Chemotherapy means the chemical or biological antineoplastic agents administered as part of a doctor's visit, home care visit, or at an outpatient facility for treatment of an illness.

Coinsurance means the percentage of the Allowed Benefit allocated between CareFirst and the Member, whereby CareFirst and the Member share in the payment for Covered Services, Covered Dental Services, or Covered Vision Services.

Contract Year means 365 days from the effective date of the In-Network Agreement each year.

Contracting Pharmacy Provider means the separate independent Pharmacist or Pharmacy, including a pharmacy in the Exclusive Specialty Pharmacy Network that has contracted with CareFirst BlueChoice or its designee to provide Prescription Drugs in accordance with the terms of this Agreement.

Contracting Provider means any physician, health care professional, health care facility or Contracting Pharmacy Provider that has contracted with CareFirst BlueChoice, Inc. to render Covered Services to Members. A Preferred Dentist who provides Covered Dental Services or a Contracting Vision Provider who provides Covered Vision Services is not a Contracting Provider for the purposes of this definition.

Contracting Vision Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Covered Vision Services are rendered when acting within the scope of such license and that has contracted with the Vision Care Designee to provide Covered Vision Services.

Convenience Item personal hygiene and convenience items, including but not limited to: air conditioners, humidifiers, physical fitness equipment, elevators, hoyer/stair lifts, ramps, shower/bath benches, and items available without a prescription

Copayment (Copay) means the fixed dollar amount that a Member must pay for certain Covered Services, Covered Dental Services or Covered Vision Services.

Cosmetic means a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst.

Covered Dental Services means Medically Necessary services or supplies listed in Section 2 of the Description of Covered Services.

Covered Prescription Drug means a Prescription Drug included in the CareFirst BlueChoice Formulary.

Covered Specialty Drug means a Specialty Drug included in the CareFirst BlueChoice Formulary.

Covered Service means Medically Necessary services or supplies provided in accordance with the terms of this Agreement other than Covered Dental Services or Covered Vision Services.

Covered Specialty Drug means a Specialty Drug included in the CareFirst BlueChoice Formulary.

Covered Vision Services means Medically Necessary services or supplies listed in Sections 3 and 4 of the Description of Covered Services.

Custodial Care means care provided primarily to meet the personal needs of the patient. Custodial Care does not require skilled medical or paramedical personnel. Such care includes help in walking, bathing, or dressing. Custodial Care also includes preparing food or special diets, feeding, administering medicine, or any other care that does not require continuing services of medically trained personnel.

Deductible means the dollar amount of the Allowed Benefits payable during a Benefit Period for Covered Services or Covered Dental Services that must first be incurred by the Member before CareFirst will make payments for Covered Services or Covered Dental Services.

Dental Director is a Dentist appointed by the Medical Director of CareFirst BlueChoice to perform administrative duties with regard to the dental services listed in this Agreement.

Dental Plan means the dental program under which the Covered Dental Services are made available to Members. The Dental Plan is offered in conjunction Group Hospitalization and Medical Services, Inc. (GHMSI), doing business as CareFirst BlueCross BlueShield (CareFirst). CareFirst contracts with Preferred Dentists and provides claims processing and administrative services under the Dental Plan.

Dentist means an individual who is licensed to practice dentistry as defined by the respective jurisdiction where the practitioner provides care.

Dependent means a Member who is covered under this Agreement as the eligible Spouse, eligible Dependent Child, eligible Domestic Partner of a Subscriber, or eligible Dependent Child of a Domestic Partner as defined in this Agreement. If the Academic Institution does not elect coverage for Dependents, these individuals are not eligible for coverage under this Agreement.

Dependent Child or Dependent Children means an eligible individual as defined in Section 2.4.

Domestic Partner means an eligible unmarried same or opposite sex adult who resides with the Member and has registered in a state or local domestic partner registry with a Member

Domestic Partnership means a relationship between the Subscriber and Domestic Partner that meets the criteria stated in Section 2.3.

Effective Date means the date on which the Member's coverage becomes effective. Covered Services, Covered Dental Services, and Covered Vision Services rendered on or after the Member's Effective Date are eligible for coverage.

Eligible Student means an individual eligible under the guidelines defined by the Academic Institution sponsoring this Agreement who is an admitted or continuing candidate in a recognized degree or certificate program sponsored by the Academic Institution. For purposes of this definition, "Candidacy in a recognized degree or certificate program" is defined as:

A. Candidacy during academic semester

   A student is an admitted or continuing candidate in a recognized degree or certificate program if the student is actively pursuing the course of study required by the degree or certificate program. The student must satisfy the requirements of his course of study which may involve maintaining minimum credit hours, research units or involvement in approved intern or work/study programs. Academic semester may include summer. Additionally, eligibility may be defined as continuing education courses, affiliated research assistantships, or post-doctoral research after graduation from a recognized degree program (e.g., a student fellowship).

B. Candidacy between academic semesters

   A student who maintains candidacy in a recognized degree or certificate program during an academic semester or session keeps such candidacy until the close of the next semester's or session's registration period.

A student's eligibility may continue in this manner until the student's candidacy is withdrawn by the student or terminated by the institution.

Emergency Medical Condition means the sudden and unexpected onset of a medical condition of sufficient severity, including severe pain, when the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

A. Serious jeopardy to the mental or physical health of the individual;

B. Danger of serious impairment of the individual's bodily functions;

C. Serious dysfunction of any of the individual's bodily organs or parts; or

D. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as CareFirst determines.

Emergency Services means, with respect to an Emergency Medical Condition:

A. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

B. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to stabilize the Member. The term to "stabilize" with respect to an Emergency Medical Condition, means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta; or as otherwise defined under 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Enhanced Monitoring Program (EMP) means the CareFirst BlueChoice program for Members with a chronic condition or disease for which medical equipment and monitoring services are provided to help the Member manage the chronic condition or disease.

Experimental/Investigational means a service or supply in the developmental stage and in the process of human or animal testing excluding patient costs for clinical trials as stated in the Description of Covered Services. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

A. The Technology* must have final approval from the appropriate government regulatory bodies;

B. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;

C. The Technology must improve the net health outcome;

D. The Technology must be as beneficial as any established alternatives; and

E. The improvement must be attainable outside the Investigational settings.

* "Technology" includes drugs, devices, processes, systems, or techniques.

A drug is not considered Experimental or Investigational as long as: it is used to treat a covered indication; it has been approved by the FDA for at least one indication; and, it is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer review medical literature.

Exclusive Specialty Pharmacy Network means a pharmacy network that is limited to certain specialty Pharmacies that have been designated as "Exclusive" by CareFirst BlueChoice. . Members may contact CareFirst BlueChoice for a list of Pharmacies in the Exclusive Specialty Pharmacy Network.

Expert Consultation Program (ECP) means the CareFirst BlueChoice Program for Members with a

complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

FDA means the United States Food and Drug Administration.

Family Caregiver means a relative by blood, marriage, or Adoption who lives with or is the primary Caregiver of the terminally ill Member.

Family Counseling means counseling given to the Immediate Family or Family Caregiver of the terminally ill Member for the purpose of learning to care for the Member and to adjust to the impending death of the Member.

Formulary means the list of Prescription Drugs issued by CareFirst and used by health care providers when writing, and Pharmacists, when filling, prescriptions for which coverage will be provided under this Agreement. CareFirst may change this list periodically without notice to Members. A copy of the Formulary is available to the Member upon request.

Generic Drug means any Prescription Drug approved by the FDA that has the same bio-equivalency as a specific Brand Name Drug.

Home Health Care or Home Health Care Services means the continued care and treatment of a Member in the home by a licensed Home Health Agency if:

A. The institutionalization of the Member in a hospital, related institution, or Skilled Nursing Facility would otherwise have been required if Home Health Care Services were not provided; and

B. The Plan of Treatment covering the Home Health Care Service is established and approved in writing by the health care provider and determined to be Medically Necessary by CareFirstBlueChoice.

Immediate Family means the Spouse, parents, siblings, grandparents, and children of the terminally ill Member.

In-Network means Point-of-Service benefits provided to the Member under this In-Network Agreement.

In-Network Agreement means this Point-of-Service In-Network agreement between CareFirst BlueChoice and the Academic Institution, and it includes thise In-Network Individual Enrollment Agreement, the [Benefit Determination and Appeal and Grievance Procedures], Description of Covered Services, Schedule of Benefits, and any duly authorized notices, amendments and riders.

Infusion Services means treatment provided by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion Services also includes enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. Infusion Services includes all medications administered intravenously and/or parenterally.

Limiting Age means the maximum age to which a Dependent Child may be covered. The Limiting Age is the age of twenty-six (26).

Low Vision means a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in Low Vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Members with Low Vision.

Maintenance Drug means a Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.

Mastectomy means the surgical removal of all or part of the breast.

Medication Assisted Treatment (MAT) means Prescription Drugs used to treat Substance Use Disorders

(Alcohol Misuse and opioid misuse).

Medical Child Support Order (MCSO) means an order issued in the format prescribed by federal law and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An order means a judgment, decree, or a ruling (including approval of a settlement agreement) that:

A. Is issued by a court or administrative child support enforcement agency of any state or the District of Columbia; and

B. Creates or recognizes the right of a child to receive benefits under a parent's health insurance coverage; or establishes a parent's obligation to pay child support and provide health insurance coverage for a child.

Medical Director means a board-certified physician who is appointed by CareFirst. The duties of the Medical Director may be delegated to qualified persons.

Medically Necessary or Medical Necessity means health care services or supplies that a health care provider, exercising clinical judgment, renders to or recommends for a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease, or its symptoms. These health care services or supplies are:

A. In accordance with generally accepted standards of medical practice;

B. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;

C. Not primarily for the convenience of a patient or health care provider; and

D. Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of the patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of health care providers practicing in relevant clinical areas, and any other relevant factors.

The fact that a health care provider may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by the Agreement.

Medical Nutrition Therapy provided by a licensed dietitian-nutritionist involves the assessment of the Member's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. The licensed dietitian-nutritionist, working in a coordinated, multidisciplinary team effort with the Primary Care Physician, takes into account a Member's condition, food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

Member means an individual who meets all applicable eligibility requirements, who is enrolled either as a Subscriber or Dependent, if the Academic Institution elects coverage for Dependents, and for whom Premiums have been collected by the Academic Institution and remitted to CareFirst BlueChoice .

Minimum Essential Coverage has the meaning given in the Affordable Care Act, 26 U.S.C. §5000A(f).

Morbid Obesity means a:

A. Body Mass Index that is greater than forty (40) kilograms per meter squared; or

B. Body Mass Index equal to or greater than thirty-five (35) kilograms per meter squared with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

Non-Contracting Physician means a licensed doctor who is not contracted with CareFirst BlueChoice to provide Covered Services to Members.

Non-Contracting Provider means any health care provider that has not contracted with CareFirst BlueChoice to provide Covered Services to Members. Neither Participating Dentists or Non-Participating Dentists who provide Covered Dental Services nor Non-Contracting Vision Providers who provide Covered Vision Services are Non-Contracting Providers for the purposes of this definition.

Non-Contracting Vision Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Covered Vision Services are rendered when acting within the scope of such license; and, who does not have an agreement with the Vision Care Designee for the rendering of Covered Vision Services. A Non-Contracting Vision Provider may or may not have contracted with CareFirst BlueChoice. The Member should contact the Vision Care Designee for the current list of Contracting Vision Providers.

Non-Preferred Dentist means any Dentist who is not a Preferred Dentist, including a Participating Dentist or a Non-Participating Dentist.

Non-Preferred Provider means a health care provider that does not contract with CareFirst to provide Covered Services. Neither Participating Dentists or Non-Participating Dentists who provide Covered Dental Services nor Non-Contracting Vision Providers who provide Covered Vision Services are Non-Preferred Providers for the purposes of this definition.

Non-Preferred Brand Name Drug means a Brand Name Drug included in the Formulary as a Covered Prescription Drug but not included on the Preferred Drug List.

Non-Preferred Specialty Drug means a Specialty Drug included in the Formulary as a Covered Prescription Drug but not included on the Preferred Drug List.

Out-of-Network means Point-of-Service benefits provided to the Member under the Out-of-Network Agreement issued to the Subscriber by CareFirst BlueCross BlueShield.

Out-of-Network Academic Institution Contract means the complete Point-of-Service Out-of-Network agreement between CareFirst BlueCross BlueShield and the Academic Institution and it includes the Academic Institution Contract Application, the Out-of-Network Academic Institution Contract, Out-of-Network Individual Enrollment Agreement, [Benefit Determination and Appeal and Grievance Procedures], Out-of-Network Description of Covered Services, Out-of-Network Schedule of Benefits, and any duly authorized notices, amendments and riders.

Out-of-Pocket Maximum means the maximum amount the Member will have to pay for his/her share of benefits in any Benefit Period. The Out-of-Pocket Maximum does not include Premiums, amounts incurred for failure to comply with utilization management requirements, the cost of services that are not Covered Services, or any balance bill. Once the Member meets the Out-of-Pocket Maximum, the Member will no longer be required to pay Copayments, Coinsurance, or Deductible for the remainder of the Benefit Period.

Outpatient Rehabilitative Services means occupational therapy, speech therapy and physical therapy provided to Members not admitted to a hospital or related institution.

Over-the-Counter means any item or supply as determined by CareFirst available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception items for men, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and related over-the-counter medications, solutions, items or supplies.

Participating Dentist means any Dentist who, at the time of rendering a Covered Dental Service to the Member, has a written agreement with CareFirst or CareFirst's designee for the rendering of such service. Participating Dentist means any Dentist who, at the time of rendering a Covered Dental Service to a Member, has a written agreement with CareFirst BlueChoice, or CareFirst BlueChoice's designee, for the rendering of such service.

Pharmacist means an individual licensed to practice pharmacy regardless of the location where the activities of practice are performed.

Pharmacy means an establishment in which prescription or nonprescription drugs or devices are compounded, dispensed, or distributed.

Plan of Treatment means the plan written and given to CareFirst BlueChoice by the attending health care provider on CareFirst BlueChoice forms which shows the Member's diagnoses and needed treatment.

Preferred Brand Name Drug means a Brand Name Drug that is included on CareFirst BlueChoice's Preferred Drug List.

Preferred Dentist means one of a network of Participating Dentists who, at the time of rendering a Covered Service to the Member, has a written agreement with the Dental Plan for the rendering of such service.

Preferred Drug List means the list of Preferred Drugs issued by CareFirst BlueChoice and used by health care providers when writing, and Pharmacists, when filling, prescriptions. All Generic Drugs are included in the Preferred Drug List. Not all Brand Name Drugs listed in the Formulary are included in the Preferred Drug List. CareFirst BlueChoice may change this list periodically without notice to Members. A copy of the Preferred Drug List is available to the Member upon request.

Preferred Specialty Drug means a Specialty Drug included in the Preferred Drug List.

Premium. means the dollar amount the Academic Institution on behalf of the Subscriber remits to CareFirst for health care benefits provided under both the In-Network Agreement and the Out-of-Network Agreement.

Premium Due Date is the date determined by CareFirst.

Prescription Drug means:

A. A drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;"

B. Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst BlueChoice ;

C. A covered Over-the-Counter medication or supply; or

D. Any Diabetic Supply.

E. Prescription Drugs do not include:

1. Compounded bulk powders that contain ingredients that:

a) Do not have FDA approval for the route of administration being compounded, OR

b) Have no clinical evidence demonstrating safety and efficacy, OR

c) Do not require a prescription to be dispensed.

2. Compounded drugs that are available as a similar commercially available Prescription Drug unless:

   a) There is no commercially available bio-equivalent Prescription Drug; OR

   b) The commercially available bio-equivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

Prescription Guidelines means the limited list of Prescription Drugs issued by CareFirst BlueChoice for which providers, when writing, and Pharmacists, when filling prescriptions, must obtain prior authorization from CareFirst BlueChoice, the quantity limits that CareFirst BlueChoice has placed on certain drugs. A copy of the Prescription Guidelines is available to the Member upon request.

Preventive Drug means. Prescription Drug or Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is included on the CareFirst BlueChoice Preventive Drug List.

Preventive Drug List means the list issued by CareFirst BlueChoice of Prescription Drugs or Over-theCounter medications or supplies dispensed under a written prescription by a health care provider that have been identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration. A copy of the Preventive Drug List is available to the Member upon request.

Primary Care Physician (PCP) means a Contracting Provider selected by a Member to provide and manage the Member's health care. PCP means health care practitioners in the following disciplines:

A. General internal medicine;

B. Family practice medicine;

C. General pediatric medicine; or

D. Geriatric medicine.

Services rendered by Specialists in the disciplines above will be treated as PCP visits for Member payment purposes.

Professional Nutritional Counseling means individualized advice and guidance given to a Member at nutritional risk due to nutritional history, current dietary intake, medication use, or chronic illness or condition, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a licensed dietitian-nutritionist, physician, physician assistant, or nurse practitioner.

Qualified Home Health Agency means a licensed program approved for participation as a home health agency under Medicare, or certified as a home health agency by the Joint Commission on Accreditation of Healthcare Organizations, its successor, or the applicable state regulatory agency.

Qualified Hospice Care Program means a coordinated, interdisciplinary program provided by a hospital, Qualified Home Health Agency, or other health care facility licensed or certified by the state in which it operates as a hospice program and is designed to meet the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and

bereavement period. Benefits are available to:

A. Individuals who have no reasonable prospect of cure as estimated by a physician; and

B. The immediate families or Family Caregivers of those individuals.

Qualified Medical Support Order (QMSO) means a Medical Child Support Order, issued under state law or the laws of the District of Columbia, that is issued to an employer sponsored health plan that complies with section 609(A) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Rescind or Rescission means a termination, cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual's enrollment is a Rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a Rescission for this purpose. Coverage is not Rescinded and a cancellation or discontinuance of coverage is not a Rescission if:

A. The termination, cancellation or discontinuance of coverage has only a prospective effect; or

B. The termination, cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due.

Respite Care means temporary care provided to the terminally ill Member to relieve the Caregiver/Family Caregiver from the daily care of the Member.

Respiratory Therapy means the use of dry or moist gases in the lungs, non pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; bronchopulmonary drainage and breathing exercises.

Service Area means the clearly defined geographic area in which CareFirst BlueChoice has arranged for the provision of health care services to be generally available and readily accessible to Members, except for emergency services. CareFirst may amend the defined Service Area at any time by notifying the Subscriber in writing.

The Service Area is as follows: the District of Columbia; the state of Maryland; in the Commonwealth of Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the areas of Fairfax and Prince Williams Counties in Virginia lying east of Route 123.

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that is accredited or approved under Medicare or The Joint Commission and provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care, or rehabilitation services. Inpatient skilled nursing is for patients who are medically fragile with limited endurance and require a licensed health care professional to provide skilled services in order to ensure the safety of the patient and to achieve the medically desired result. Inpatient skilled nursing services must be provided on a 24 hour basis, 7 days a week.

Sound Natural Teeth means teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers, and crowns) that are in good condition; absent decay, fracture, bone loss, periodontal disease, root canal pathology or root canal therapy and excludes any tooth replaced by artificial means (implants, fixed or removable bridges, dentures).

Special Enrollment Period means a period during which a eligible individual who experiences certain one or more qualifying events may enroll in, or change enrollment under this Agreement outside of any Annual Open Enrollment Period.

Specialist means a licensed health care provider who is certified or trained in a specified field of medicine.

Specialty Drug means high-cost injectables, infused, oral or inhaled Prescription Drugs that:

A. Is prescribed for an individual with a complex or chronic medical condition or a rare medical condition, including but not limited to, the following: Hemophilia, Hepatitis C, Multiple Sclerosis, Infertility Treatment Management, Rheumatoid Arthritis, Psoriasis, Crohn's Disease, Cancer (oral medications), and Growth Hormones;

B. Costs $ 600 or more for up to the dispensing amount for non-Maintenance Drugs stated in the Schedule of Benefits

C. Is not typically stocked at retail pharmacies; and,

D. Requires:

1. A difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug; or

2. Enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

E. As used in this definition, the following terms have the meanings described below:

1. Complex or chronic medical condition means a physical, behavioral, or developmental condition that:

a) may have no known cure;

b) is progressive; or

c) can be debilitating or fatal if left untreated or undertreated.

2. Rare medical condition means a disease or condition that affects fewer than:

a) 200,000 individuals in the United States; or

b) approximately 1 in 1,500 individuals worldwide.

Spouse means a person of the same or opposite sex who is legally married to the Subscriber under the laws of the state or jurisdiction in which the marriage was performed. If the Academic Institution includes coverage of Dependents, a Spouse also includes a Domestic Partner, as defined in Section 2.3.

Step Therapy or Fail-First Protocol means a protocol established by CareFirst BlueChoice that requires a Prescription Drug or sequence of Prescription Drugs to be used by a Member before a Prescription Drug ordered by the Member's provider is covered.

Subscriber means the Eligible Student to whom this In-Network Agreement has been issued.

Substance Use Disorder means:

A. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or

B. Drug Use Disorder means a disease that is characterized by a pattern of pathological use

of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Substance Use Disorder Program means the CareFirst BlueChoice program for Members with a diagnosed Substance Use Disorder. The program includes ambulatory/outpatient detoxification, individual therapy, group therapy and medication assisted therapy.

Urgent Care means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the hospital emergency room. An Urgent Care facility is a freestanding facility that is not a physician's office and which provides Urgent Care.

Vision Care Designee means the entity with which CareFirst has contracted to administer Vision Care. [CareFirst's Vision Care Designee is [Davis Vision, Inc.].] [[Davis Vision, Inc.] is an independent company and administers the Vision Care benefits on behalf of CareFirst.]

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage.

A. The individual must be eligible for coverage either as a Subscriber or if applicable, as a Dependent;

B. The Subscriber and any Dependent, if applicable, must timely enroll as provided in Section 2.7 and CareFirst BlueChoice must receive Premium payments from the Academic Institution for each enrolled Member.

2.2 Eligibility for Student Health Center Services

A. The Academic Institution's student health center will determine who is eligible to receive Covered Services at the health center.

B. Dependents who are not Eligible Students may not be eligible to receive Covered Services at a student health center.

2.3 Eligibility of Subscriber's Spouse. If the Academic Institution has elected to include coverage for Dependents, then the Subscriber may enroll an individual that is his or her Spouse as a Dependent. A Subscriber cannot cover a former Spouse once divorced or if the marriage had been annulled. Premium changes resulting from the enrollment of a Spouse will be effective as determined by CareFirst BlueChoice.

2.4 Eligibility of Subscriber's Domestic Partner. If the Academic Institution has elected to include coverage for Dependents, then the Subscriber may enroll an individual that is his or her eligible Domestic Partner. A Domestic Partner will be eligible for coverage to the same extent as a Subscriber's Spouse.

A. Requirements for Coverage. To be eligible for coverage as the Domestic Partner of a Subscriber, the following conditions must be met:

1. The individual must be eligible for coverage as a Domestic Partner as defined in Section 2.3(B);

2. The Subscriber must elect coverage for his/her Domestic Partner; and

3. Premium payments must be made as required under this Agreement.

B. Domestic Partnership means a relationship between a Subscriber and a Domestic Partner that satisfies the requirements of either section below:

1. The Subscriber and Domestic Partner are lawfully married under the laws of any state or are registered with any state or local government agency authorized to perform such registrations. There are no requirements for proof of relationship that are not also applied to any other married couple.

2. If the requirement in Section 2.3(B)(1) above has not been met, the Subscriber and Domestic Partner must meet all of the following requirements:

a) The Subscriber and the Domestic Partner are the same sex or opposite sex and both are at least eighteen (18) years of age and have the legal capacity to enter into a contract;

b) The Subscriber and the Domestic Partner are not parties to a legally recognized marriage with anyone else and are not in a civil union or domestic partnership with anyone else;

c) The Subscriber and Domestic Partner are not related to the other by blood or marriage within four (4) degrees of consanguinity under civil law rule;

d) The Subscriber and Domestic Partner share a common primary residence. The Subscriber must submit one (1) of the following documents as proof of a shared common primary residence:

(1) Common ownership of the primary residence via joint deed or mortgage agreement;

(2) Common leasehold interest in the primary residence;

(3) Driver's license or State-issued identification listing a common address; or

(4) Utility or other household bill with both the name of the Subscriber and the Domestic Partner appearing; and

e) The Subscriber and Domestic Partner are Financially Interdependent, and submit documentary evidence of their committed relationship of financial interdependence, existing for at least six (6) consecutive months prior to application.

C. Financially Interdependent means the Subscriber and Domestic Partner can establish that they are in a committed relationship of mutual interdependence in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely. Financial Interdependence can be established by submitting documentation from any one (1) of the following criteria:

1. Joint bank account or credit account;

2. Designation of one partner as the other's primary beneficiary with respect to life insurance or retirement benefits.

3. Designation of one partner as the primary beneficiary under the other partner's will;

4. Mutual assignments of valid durable powers of attorney under the applicable laws of any state or the District of Columbia;

5. Mutual valid written advanced directives under the applicable laws of any state or the District of Columbia, approving the other partner as health care agent;

6. Join ownership or holding of investments; or

7. Joint ownership or lease of a motor vehicle.

2.5 Eligibility of Children. If the Academic Institution has elected to include coverage for Dependents, then the Subscriber may enroll an individual that is an eligible Dependent Child. An individual who is the child of Domestic Partner is eligible for coverage as any other Dependent Child, if the Domestic Partner and the child of the Domestic Partner meet the qualifications for coverage. A Dependent Child means an individual who:

A. Is:

1. The natural child, stepchild, r adopted child or foster child of the Subscriber;

2. A child placed with the Subscriber, the Subscriber's Spouse or the Subscriber's eligible Domestic Partner for legal Adoption;

3. An individual under testamentary or court appointed guardianship, other than temporary guardianship for less than twelve (12) months' duration, of the Subscriber, the Subscriber's Spouse or the Subscriber's eligible Domestic Partner; or

4. An unmarried grandchild who is in the court-ordered custody, and who resides with, and is a dependent of the Subscriber, the Subscriber's Spouse, or eligible Domestic Partner.

B. Is under the Limiting Age of twenty-six (26); or

C. Is an individual who is the subject of a Medical Child Support Order that creates or recognizes the right of the child to receive benefits under the health insurance coverage of the Subscriber, the Subscriber's covered Spouse or the Subscriber's covered Domestic Partner.

D. Premium changes resulting from the enrollment of a Dependent Child will be effective as determined by CareFirst.

2.6 Limiting Age for Covered Dependent Children.

A. All covered Dependent Children are eligible up to the Limiting Age of twenty-six (26).

B. A covered Dependent Child will be eligible for coverage past the Limiting Age if, at the time coverage would otherwise terminate:

1. The Dependent Child is unmarried and is incapable of self-support or maintenance because of intellectual disability or physical handicap;

2. The Dependent Child is primarily dependent upon the Subscriber or the Subscriber's covered Spouse or Domestic Partner for support and maintenance;

3. The intellectual disability or physical handicap occurred before the covered Dependent Child reached the Limiting Age; and

4. The Subscriber provides CareFirst BlueChoice with proof of the Dependent Child's intellectual disability or physical handicap within thirty-one (31) days after the Dependent Child reaches the Limiting Age for Dependent Children. CareFirst BlueChoice has the right to verify whether the child is and continues to qualify as an incapacitated Dependent Child.

2.7 Open Enrollment Opportunities and Effective Dates. Eligible individuals may elect coverage as a Subscriber or Member, as applicable, only during the Annual Enrollment Period or Special Enrollment Period.

A. Annual Open Enrollment. During an Annual Open Enrollment Period, an Eligible Student may enroll (or waive coverage, as applicable) as a Subscriber through the process specified by the Academic Institution and approved by CareFirst. Subscribers may also enroll eligible Dependents if the Academic Institution has elected to include coverage for Dependents through the process specified by the Academic Institution and approved by CareFirst BlueChoice.

B. Special Enrollment. If an eligible individual does not enroll during an Annual Open Enrollment Period, he or she may only enroll during a Special Enrollment Period:

1. An eligible individual may enroll as a Subscriber or Dependent, if the Academic Institution has elected to include coverage for Dependents, upon the occurrence of one of the following qualifying events:

a. The eligible individual or a Dependent:

(1) Loses Minimum Essential Coverage. A loss of Minimum Essential Coverage. For example, those that are the result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, and reduction in the number of hours of employment.

Loss of coverage described herein includes those circumstances such as an employee or dependent who has coverage that is not COBRA continuation coverage; termination of employer contributions; or, exhaustion of COBRA continuation coverage Loss of coverage does not include voluntary termination of coverage or other loss due to:

(2) Failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA coverage; or

(3) Situations allowing for a Rescission.

b. Is enrolled in any non-Calendar Year health insurance policy even if the Qualified Individual or his or her Dependent has the option to renew non-Calendar Year health insurance policy. The date of the loss of coverage is the last day of the non-Calendar Year policy year.

c. Loses pregnancy-related coverage such as prenatal, delivery, and postpartum services. The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage; or loses medically needy coverage as described only once per calendar year. The date of the loss of coverage is the last day the consumer would have medically needy coverage

d. The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation or if the enrollee or his or her Dependent dies.

e. Loses coverage as a result of spouse moving to a Medicare plan resulting in the loss of coverage for eligible individual.

f. An eligible individual gains, or becomes, if the Academic Institution has elected to include coverage for Dependents, a Dependent, through marriage, domestic partnership, birth, adoption, placement for adoption, grant of court or testamentary guardianship, child support order (MCSO) or other court order, or placement of a child for foster care. The foster child is not eligible for coverage under this Agreement.

g. In the case of marriage, at least one Spouse must demonstrate that he or she:

(1) had minimum essential coverage for one or more days during the sixty (60) days preceding the date of marriage or demonstrates that he or she had pregnancy related coverage, had access to healthcare related services through unborn child coverage, or had medically needy coverage; or,

(2) was living in a foreign country or in a United States territory for one or more days during the sixty (60) days preceding the date of marriage; or,

(3) is an Indian as defined by section 4 of the Indian Health Care Improvement Act; or,

(4) lived for one (1) or more days during the sixty (60) days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no qualified health plan was available.

h. Within 6 months after the death of a spouse, a Subscriber may exercise the addition of a Subscriber's dependent children to the Agreement.

i. The eligible individual or his or her Dependent become eligible as a result of a permanent move and either:

(1) (1) had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the sixty (60) days preceding the date of the permanent move; or,

(2) was living in a foreign country or in a United States territory at the time of the permanent move.

(3) lived for one (1) or more days during the sixty (60) days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no qualified health plan was available; or

(4) is an Indian as defined by Section 4 of the Indian Health Care Improvement Act.

The eligible individual or his or her Dependent may access this Special Enrollment Period sixty (60) days before or after the date of the permanent move.

j. The eligible individual is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B-2T, or a Dependent or unmarried victim within a household, who is enrolled in minimum essential coverage and sought to enroll in coverage separate from the perpetrator of the abuse or abandonment. A Dependent of a victim of domestic abuse or spousal abandonment on the same application as the victim may enroll in coverage at the

k. If an eligible individual did not timely enroll during an Annual Open Enrollment Period or during the time period specified by the Academic Institution because he or she already had coverage under an employer sponsored health plan or a group health benefits plan, he or she may enroll as a Subscriber or Dependent, if the Academic Institution has elected to include coverage for Dependents, under this Agreement due to any of the following qualifying events:

l. Termination (other than by reason of such employee's gross misconduct) of the employee covered under the other employer sponsored plan or group health benefits plan.

C. Effective Dates.

1. Annual Open Enrollment Effective Dates. The Effective Date for an eligible individual who timely enrolls during an Annual Open Enrollment Period is the first day of the Contract Year, or the first day of the semester applicable to that Annual Open Enrollment Period as specified by the Academic Institution and approved by CareFirst BlueChoice.

2. The Effective Date for a Dependent Child who timely enrolls during a Special Enrollment Period is the Dependent Child's First Eligibility Date:

a) First Eligibility Date means:

(1) For a newborn Dependent Child, the child's date of birth;

(2) For a newly adopted Dependent Child, the earlier of:

(a) A judicial decree of Adoption; or

(b) Placement of the child in the Subscriber's home as the legally recognized proposed adoptive parent; or,

(3) For a Dependent Child for whom guardianship has been granted by court or testamentary appointment or the date of the appointment.

(4) For a child placed for foster care, the date of placement of the child by the foster care agency. The foster child is not eligible for coverage under this In-Network Agreement.

(5) For a child subject to a child support order (MCSO or other court order), the date of the child support order.

b) The Dependent Child will be covered automatically, but only for the first thirty-one (31) days following the child's First Eligibility Date. The Subscriber must enroll such a Dependent Child within sixty (60) days of the child's First Eligibility Date when an additional premium is due for the enrollment of the Dependent Child. Otherwise, the Dependent Child will not be covered and cannot be enrolled until the next Annual Open Enrollment Period. (An additional premium will be due unless there are three (3) or more Dependent Children under the age of twenty-one (21) already enrolled by the Subscriber).

3. The Effective Date for a Spouse who becomes a new Dependent and who timely enrolls during a Special Enrollment Period shall be the first day of the month following the receipt of enrollment by CareFirst BlueChoice.

4. The Effective Date for an eligible individual or Dependent who loses other Minimum Essential Coverage who timely enrolls during a Special Enrollment Period shall be the first day of the month following the receipt of enrollment by CareFirst BlueChoice.

5. The Effective Date for an individual who becomes a newly Eligible Subscriber will be the date as determined by CareFirst.

6. In all other cases, the Effective Date for an individual or Dependent who timely enrolls during a Special Enrollment Period will be:

a) For enrollment received by CareFirst BlueChoice between the first and the fifteenth day of the month, the first day of the following month; and

b) For enrollment received by CareFirst BlueChoice between the sixteenth and the last day of the month, the first day of the second following month.

7. Premium changes resulting from the enrollment of a Subscriber or a Dependent during a Special Enrollment Period will be effective as determined by CareFirst BlueChoice.

D. A Dependent of an eligible individual is not eligible for a Special Enrollment Period if the Academic Institution does not extend the offer of coverage to Dependents.

2.8 Medical Child Support Orders (MCSO or QMSO). This provision does not apply if the Academic

Institution does not extend the offer of coverage to Dependents.

A. Eligibility and Termination.

1. Upon receipt of an MCSO or QMSO, CareFirst BlueChoice will accept enrollment of a child that is the subject of an MCSO or QMSO. Coverage will be effective as of the date of the order, and the Premium will be adjusted as needed. If the Subscriber does not enroll the child then CareFirst BlueChoice will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any state or the District of Columbia. If the Subscriber is subject to a Waiting Period, the child will not be enrolled until the end of the Waiting Period.

2. Enrollment for such a child will not be denied because the child:

a) Was born out of wedlock;

b) Is not claimed as a dependent on the Subscriber's federal tax return;

c) Does not reside with the Subscriber; or

d) Is covered under any Medical Assistance or Medicaid program.

3. Coverage required by an MCSO or QMSO will be effective as of the date of the order.

4. Termination. Unless coverage is terminated for non-payment of the Premium, a covered child subject to an MCSO or QMSO may not be terminated unless written evidence is provided to CareFirst stating:

a) The MCSO or QMSO is no longer in effect; or

b) The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the date of the termination of coverage.

c) The Academic Institution has eliminated family members' coverage for all its students; or

d) The insuring parent is no longer an Eligible Student.

B. Administration**.** When the child subject to an MCSO or QMSO does not reside with the Subscriber, CareFirst BlueChoice will:

1. Send to the non-insuring custodial parent the identification cards, claims forms, the applicable Agreement and any information needed to obtain benefits;

2. Allow the non-insuring custodial parent or a provider of a Covered Service to submit a claim without the approval of the Subscriber; and

3. Provide benefits directly to:

a) The non-insuring parent;

b) The provider of the Covered Services, Covered Dental Services or Covered Vision Services;

c) The appropriate child support enforcement agency of any state or the District of Columbia; or

d) The Department of Medical Assistance Services, as the payor of last

resort.

2.9 Clerical or Administrative Error. If an individual is ineligible for coverage, the individual cannot become eligible just because CareFirst BlueChoice made a clerical or administrative error in recording or reporting information. Likewise, if a Member is eligible for coverage, the Member will not lose coverage because CareFirst BlueChoice o made an administrative or clerical error in recording or reporting information.

2.10 Cooperation and Submission of Information. The Subscriber agrees to cooperate with and assist CareFirst BlueChoice , including providing CareFirst BlueChoice with reasonable access to eligibility records upon request. At any time that coverage is in effect, CareFirst BlueChoice reserves the right to request documentation substantiating eligibility.

Knowingly attempting to obtain, or actually obtaining eligibility for any person known to the Subscriber to be ineligible pursuant to the eligibility provisions stated in this In-Network Agreement, shall constitute an act or practice constituting fraud or an intentional misrepresentation of material fact and in addition to the remedies related to Rescission provided in this In-Network Agreement, CareFirst BlueChoice reserves to itself any and all rights provided by law for such act or acts.

SECTION 3
PREMIUMS AND PAYMENT

3.1. Premiums. All Premiums shall be paid to CareFirst BlueChoice by the Academic Institution. The initial Premium is due to CareFirst BlueChoice on the date as determined by CareFirst BlueChoice. It is the obligation of the Academic Institution to remit payment to CareFirst, BlueChoice as such obligations are described in the Academic Institution Contract between CareFirst BlueChoice and the Academic Institution

If the Academic Institution elects an electronic payment, CareFirst BlueChoice will not debit or charge the amount of the Premium due prior to the Premium Due Date, except as authorized by the Academic Institution.

3.2 Grace Period.

All Premiums shall be paid to CareFirst BlueChoice by the Academic Institution. Except for the initial Premium(s), there is a grace period of 31 days within which overdue Premiums can be paid without loss of coverage. The 31-day grace period begins on the Premium Due Date. The grace period will be granted for the payment of each Premium by the Academic Institution falling due after the first Premium. This Agreement shall continue in force during the grace period.

If Premiums have not been received by the Premium Due Date, CareFirst Blue Choice will notify the Academic Institution in writing of the overdue Premiums. If CareFirst receives payment by the Academic Institution of all amounts listed on the notice prior to the end of the 31-day grace period, coverage will continue without interruption. If CareFirst BlueChoice does not receive full payment by the Academic Institution prior to the end of the grace period, the Subscriber's and any Member's coverage will terminate effective as of midnight on the last day of the grace period. No additional Premiums will be charged for the time coverage continued in force under the grace period.

3.3 Reinstatement. A Subscriber may apply for reinstatement of a terminated policy if the Subscriber believes the policy was terminated due to an error by CareFirst. All reinstatement requests must be approved by the Exchange and may be declined. Under no circumstances will CareFirst or the Exchange automatically reinstate a terminated policy.

3.4 Premium Adjustments. All Premium adjustments for Members enrolling or terminating during a coverage month will be made by CareFirst BlueChoice.

3.5 Premium Rate Changes. There may be a Premium rate change when approved by the District of Columbia Department of Insurance, Securities and Banking, as provided by law. CareFirst BlueChoice will not increase the Subscriber's Premium more frequently than once every Contract Year. CareFirstBlueChoice will provide notice of the change to Premiums by giving the Academic Institution at least sixty (60) days prior written notice. Any change in Premium rates, including changes in a Member's Premium rate due to a change in a Member's age, will be effective on the effective date each Contract Year when this Agreement renews.

CareFirstBlueChoice may change the Premium during a Contract Year if the change is due solely to a mistake impacting the Premium rate or due to the enrollment or termination of a Dependent.

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Agreement.

A. The Agreement shall terminate if Premium has not been paid in full by the Academic Institution.

B. The Subscriber may terminate the Agreement if coverage is no longer required by the Academic Institution.

C. Termination of Subscriber's enrollment at the Academic Institution. The Subscriber's and any Dependent's coverage will be terminated as follows if the Subscriber is no longer enrolled in the Academic Institution:

1. If termination of enrollment at the Academic Institution occurs during the first six (6) months of the Benefit Period, coverage will end at the end of the first six (6) months of Benefit Period.

2. If termination of enrollment at the Academic Institution occurs during the second six (6) months of the Benefit Period, coverage will continue until the end of the Benefit Period.

3. The Subscriber may request an earlier termination under Section 4.1C if no longer enrolled in the Academic Institution. If an earlier termination date is requested, Premiums will be refunded on a pro-rata basis, as applicable. The Subscriber is required to notify the Academic Institution of termination under Section 4.1C.3, and the Academic Institution is required to issue any applicable refund.

D. The Academic Institution must provide written notification to CareFirst BlueChoice of any such terminations under Section 4.1.A through 4.1.C. Termination shall be without prejudice to any claim originating prior to the effective date of the cancellation.

E. Termination of Dependent Coverage.

1. For all Dependents, coverage will terminate on the same date that coverage terminates for the Subscriber.

2. Except for a Dependent Child reaching the Limiting Age, a Dependent's coverage will terminate at the [end of month][end of the semester] [end of the Benefit Period]in which the Dependent became no longer eligible if there is a change in their status or relationship to the Subscriber, such that they no longer meet the eligibility requirements of this Agreement.

3. For a Dependent Child reaching the Limiting Age, coverage will terminate at the [end of month][end of the semester] [end of the Benefit Period] in which the Dependent reaches the Limiting Age.

The Subscriber is responsible for notifying the Academic Institution of any changes in the status of a Dependent which affects his or her eligibility for coverage under this Agreement, and the Academic Institution will notify CareFirst BlueChoice. These changes include a death or divorce. If the Subscriber does not notify the Academic Institution of these types of changes and it is later determined that a Dependent was not eligible for coverage, CareFirst BlueChoice may rescind the Agreement and recover the full value of the services and benefits provided during the period of ineligibility if fraud or intentional misrepresentation was involved in the failure to provide notification of any changes in the status of a Dependent which affects his or her eligibility under this

Agreement.

F CareFirst BlueChoice elects not to renew all of its individual health benefit plans in the state or jurisdiction. In this case, CareFirst BlueChoice:

1. Shall give notice of this decision to all affected individuals at least one hundred eighty (180) days before the effective date of non-renewal; and

2. Shall give notice to all affected individuals at least one hundred eighty (180) days before the effective date of non-renewal of the individual's option to purchase all other individual health benefit plans currently offered by an affiliate of CareFirst.

.

4.2 Rescission of Enrollment for Fraud or Misrepresentation. This Agreement, or the enrollment of a Member, may be Rescinded if:

A. The Member has performed an act, practice, or omission that constitutes fraud;

B. The Member has made an intentional misrepresentation of material fact; or

C. An act, practice or omission that constitutes fraud includes, but is not limited to, fraudulent use of CareFirst's identification card by the Member, the alteration or sale of prescriptions by the Member, or an attempt by a Subscriber to enroll non-eligible persons.

CareFirst BlueChoice will provide thirty (30) days advance written notice of any Rescission. CareFirst shall have the burden of persuasion that its Rescission complies with applicable state law. The Rescission shall either (i) void the enrollment of the Member and any benefits paid as of the Member's Effective Date (for fraudulent acts, practices, or omissions that occur at the time of enrollment); or (ii) in all other cases, void the enrollment of the Member and any benefits paid as of the first date the Member performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of material fact. The Subscriber will be responsible for payment of any voided benefits paid by CareFirst BlueChoice , net of applicable Premiums paid. Any Premiums paid from the date of coverage being voided or Rescinded will be refunded to the Subscriber.

4.3 Cancellation of Dependent Coverage by the Subscriber.

A. Except as provided in paragraph 4.4B, the Subscriber may terminate the coverage of an eligible Dependent. The effective date of the termination will be the [end of month] [end of the semester] [end of the Benefit Period]of the receipt by CareFirst BlueChoice of the notice of termination from the Academic Institution. If coverage is terminated under this Section, CareFirst BlueChoice will not be required to give notice of termination to the Subscriber or to the Dependents.

B. If a Dependent Child is enrolled under this Agreement pursuant to a MCSO, as described in Section 2.7, the Subscriber may not terminate or cancel the coverage of such child except as specifically provided in Section 2.7.

4.4 Death of Dependent. In case of the death of a Dependent, the enrollment of the deceased Dependent shall terminate as of the date of the Dependent's death.

4.5 Death of Subscriber. In case of the death of the Subscriber, this Agreement shall terminate on the date of the Subscriber's death if there are no Dependents enrolled under this Agreement. If Dependents are enrolled, this Agreement shall terminate on the last day of the month in which the Subscriber's death occurs.

4.6 Effect of Termination. No benefits will be provided for any services received on or after the date

on which this Agreement terminates. This includes services received for an injury or illness that occurred before the date of termination.

SECTION 5
COORDINATION OF BENEFITS (COB)

5.1 Coordination of Benefits (COB).

A. Applicability.

1. This Coordination of Benefits (COB) provision applies to this CareFirst BlueChoice Plan when a Member has health care coverage under more than one Plan.

2. If this COB provision applies, the Order of Benefit Determination Rules should be reviewed first. Those rules determine whether the benefits of this CareFirst BlueChoice Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:

a) Shall not be coordinated when, under the order of determination rules, this CareFirst Plan determines its benefits before another Plan;

b) May be coordinated when, under the order of determination rules, another Plan determines its benefits first. The coordination is explained in Section 5.1D.2.

B. Definitions. For the purpose of this COB section, the following terms are defined. The definitions of other capitalized terms are found in the definitions section of this Agreement.

Allowable Expenses means any health care expense, including deductibles, coinsurance or copayments that are covered in whole or in part by any of the Plans covering the Member. This means any expense or portion of an expense not covered by any of the Plans is not an Allowable Expense. If this CareFirst BlueChoice Plan is advised by a Member that all Plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account, the primary Plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible, as stated in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

CareFirst BlueChoice Plan means this In-Network Agreement.

Intensive Care Policy means a health insurance policy that provides benefits only when treatment is received in a specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

Plan means any health insurance policy, including those of a nonprofit health service plan, those of a commercial, group, and blanket policy, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage required or provided by law and coverage under a governmental plan, except a governmental plan which, by law, provides benefits in excess of those of any private insurance plan or other non-governmental plan. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

The term Plan does not include:

1. An individually underwritten and issued, guaranteed renewable, specified disease policy;

2. An intensive care policy, which does not provide benefits on an expense incurred basis;

3. Coverage regulated by a motor vehicle reparation law;

4. The first one-hundred dollars ($100) per day of a hospital indemnity contract; or

5. An elementary and/or secondary school insurance program sponsored by a school or school system.

Primary Plan or Secondary Plan means the order of benefit determination rules stating whether this CareFirst BlueChoice Plan is a Primary Plan or Secondary Plan as to another Plan covering the Member.

1. When this CareFirst BlueChoice Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

2. When this CareFirst BlueChoice Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be coordinated because of the other Plan's benefits.

3. When there are more than two Plans covering the Member, this CareFirst BlueChoice Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Specified Disease Policy means a health insurance policy that provides (1) benefits only for a disease or specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease specified in the policy or for treatment unique to a specified disease.

C. Order of Benefit Determination Rules.

1. General. When there is a basis for a claim under this CareFirst BlueChoice Plan and another Plan, this CareFirst BlueChoice Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

   a) The other Plan has rules coordinating benefits with those of this CareFirst BlueChoice Plan; and

   b) Both those rules and this CareFirst Plan's rules require this CareFirst BlueChoice Plan's benefits be determined before those of the other Plan.

2. Rules. This CareFirst BlueChoice Plan determines its order of benefits using the first of the following rules which applies:

   a) Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

      (1) Secondary to the Plan covering the person as a dependent, and

      (2) Primary to the Plan covering the person as other than a dependent (e.g., retired employee),

Then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

b) Dependent Child covered by more than one Plan. Unless there is a court decree stating otherwise, when this CareFirst BlueChoice Plan and another Plan cover the same child as a dependent, the order of benefits shall be determined as follows:

(1) For a Dependent Child whose parents are married or are living together:

(a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but

(b) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

(2) For a Dependent Child whose parents are separated, divorced, or are not living together:

(a) If the specific terms of a court decree state one of the parents is responsible for the health care expenses or health care coverage of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with responsibility has no health care coverage for the Dependent Child's health care expenses, but the parent's Spouse does, that parent's Spouse's plan is the primary plan. This paragraph does not apply with respect to any claim for services rendered before the entity has actual knowledge of the terms of the court decree.

The rule described in (1) above also shall apply if: i) a court decree states both parents are responsible for the Dependent Child's health care expenses or health care coverage, or ii) a court decree states the parents have joint custody without specifying one parent has responsibility for the health care expenses or coverage of the Dependent Child.

(b) If there is no court decree setting out the responsibility for the child's health care expenses or health care coverage, the order of benefits for the Dependent Child are as follows:

i) The Plan of the parent with custody of the child;

ii) The Plan of the Spouse of the parent with the custody of the child;

iii) The Plan of the parent not having custody of the child; and then

iv) The Plan of the Spouse of the parent who does not have custody of the child.

(3) For a Dependent Child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the rules stated in (1) and (2) of this paragraph as if those individuals were parents of the child.

c) Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired is determined before those of a Plan that covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as an employee who is neither laid off nor retired or a person covered as a laid off or retired employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

d) Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefits determination:

(1) First, the benefits of a Plan covering the person as an employee, retiree, member or subscriber (or as that person's dependent);

(2) Second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

e) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter term.

D. Effect on the Benefits of this CareFirst BlueChoice Plan.

1. When this Section Applies. This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst BlueChoice Plan is a Secondary Plan as to one or more other Plans. In such an event, the benefits of this CareFirst BlueChoice Plan may be coordinated under this section. Any additional other Plan or Plans are referred to as "the other Plans" immediately below.

2. Coordination in this CareFirst BlueChoice Plan's Benefits. When this CareFirst BlueChoice Plan is the Secondary Plan, the benefits under this CareFirst Plan *may* be coordinated so that the total benefits that would be payable or provided by all the other Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. If the benefits of this CareFirst Plan are coordinated, each benefit is coordinated in proportion. It is then charged against any applicable benefit limit of this CareFirst BlueChoice Plan.

E. Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. CareFirst BlueChoice has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. CareFirst BlueChoice need

not tell, or get the consent of, any person to do this. Each person claiming benefits under this CareFirst BlueChoice Plan must give this CareFirst BlueChoice Plan any facts it needs to pay the claim.

F. Facility of Payment. A payment made under another Plan may include an amount that should have been paid under this CareFirst BlueChoice Plan. If it does, this CareFirst BlueChoice Plan may pay the amount to the organization that made that payment. The amount will then be treated as though it were a benefit paid under this CareFirst BlueChoice Plan. This CareFirst BlueChoice Plan will not have to pay the amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery. If the amount of the payments made by this CareFirst BlueChoice Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;

2. Insurance companies; or

3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

5.2 Medicare Eligibility. This provision applies to Members who are entitled to Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of sixty-five (65) or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in the Agreement. Benefits covered by Medicare are subject to the provisions in this section.

A. Coverage Secondary to Medicare. Except where prohibited by law, the benefits under this CareFirst BlueChoice Plan are secondary to Medicare.

B. Medicare as Primary.

1. When benefits for Covered Services, Covered Dental Services or Covered Vision Services are paid by Medicare as primary, this CareFirst BlueChoice Plan will not duplicate those payments. CareFirst BlueChoice will coordinate and pay benefits based on Medicare's payment (or the payment Medicare would have paid). When CareFirst BlueChoice coordinates the benefits with Medicare, CareFirst' BlueChoice s payments will be based on the Medicare allowance (if the provider is a participating provider in Medicare) or the Medicare maximum limiting charge (if the provider is not a participating provider in Medicare), less any claim reduction or denial due to a Member's failure to comply with Medicare's administrative requirements. CareFirst BlueChoice's right to coordinate is not contingent on any payment actually being made on the claim by Medicare. Members enrolled in Medicare agree to, and shall, complete and submit to Medicare, CareFirst BlueChoice, and/or any health care providers all claims, consents, releases, assignments and other documents required to obtain or assure such claim payment by Medicare.
2. If a Medicare-eligible Member has not enrolled in Medicare Part A and/or Part B, CareFirstBlueChoice will not "carve-out," coordinate, or reject a claim based on the amount Medicare would have paid had the Member actually applied for, claimed, or received Medicare benefits.

5.3 Employer or Governmental Benefits. Coverage does not include the cost of services or payment for

services for any illness, injury, or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:

A. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or

B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the United States Department of Veterans Affairs, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

5.4 Subrogation

A. CareFirst has subrogation and reimbursement rights. Subrogation requires the Member to turn over to CareFirst any rights the Member may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a Member for an injury or illness. Subrogation applies to any illness or injury which is:

1. Caused by an act or omission of a third party; or

2. Covered under a member's uninsured or underinsured policy issued to or otherwise covering the Member; or

3. Covered by No Fault Insurance. No Fault Insurance means motor vehicle casualty insurance. This term also refers to motor vehicle insurance issued under any other state or federal legislation of similar purpose.

B. If the Member receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or need for care for which benefits were provided or will be provided under this Agreement, the payment will be treated as having been paid to the Member as a recovery for the medical, hospital and other expenses for which CareFirst provided or will provide benefits. CareFirst may recover the amounts paid or will pay in benefits up to the amount received from or on behalf of the third party or applicable first party coverage.

All recoveries the Member or the Member's representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated (for example as "pain and suffering"), must be used to reimburse CareFirst in full for benefits paid. CareFirst's share of any recovery extends only to the amount of benefits paid or payable to the Member, the Member's representatives, and/or health care providers on the Member's behalf. For purposes of this provision, "Member's representatives" include, if applicable, heirs, administrators, legal representatives, parents (if the Member is a minor), successors, or assignees. This is CareFirst's right of recovery.

C. CareFirst's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. If required by law, CareFirst will reduce the amount owed by the Member to CareFirst in accordance with applicable law.

D. CareFirst will have a lien on all funds the Member recovers up to the total amount of benefits provided. We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. CareFirst may give notice of that lien to any party who may have contributed to the Member's loss, or who may be liable for payment as a result of that loss.

E. CareFirst has the option to be subrogated to the Member's rights to the extent of the benefits provided under this Agreement. This includes CareFirst right to bring suit or file claims against the third party in the Member's name.

F. Members agree to take action, furnish information and assistance, and execute such instruments that CareFirst may require while enforcing CareFirst rights under this Section. The Member

agrees to not take any action which prejudices CareFirst's rights and interests under this provision.

SECTION 6
GENERAL PROVISIONS

6.1 Entire Agreement; Changes. Entire Agreement; Changes. The entire agreement between CareFirst BlueChoice and the Academic Institution includes: (a) the Academic Institution Contract; (b) the In-Network Student Health Plan Individual Enrollment Agreement; (c) [the Benefit Determinations and Appeals Attachment]; (d) the Description of Covered Services; (e) the In-Network Schedule of Benefits; and (f) any additional duly authorized notices, amendments and riders.
No amendment or modification of any term or provision of this Agreement shall be valid until approved by an executive officer of CareFirstBlueChoice. Any duly authorized notice, amendment or rider will be issued by CareFirst BlueChoice to be attached to the Agreement. No agent has authority to change this Agreement or to waive any of its provisions. Any waiver of to the In-Network Agreementterm or provision shall only be given effect for its stated purpose and shall not constitute or imply any subsequent waiver.

Oral statements cannot be relied upon to modify or otherwise affect the benefits, limitations and/or exclusions of this Agreement, or increase or void any coverage or reduce any benefits under this Agreement. Such oral statements cannot be used in the prosecution or defense of a claim.

6.2 Claims and Payment of Claims.

A. Claim Forms. A claim form can be requested by calling the Member and Provider Service telephone number on the identification card during regular business hours. CareFirst BlueChoice shall provide claim forms for filing proof of loss to each claimant. If CareFirst BlueChoice does not provide the claim forms within fifteen (15) days after notice of claim is received, the claimant is deemed to have complied with the requirements of the policy as to proof of loss if the claimant submits, within the time fixed in the policy for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

When a child subject to a Medical Child Support Order or a Qualified Medical Support Order does not reside with the Subscriber, CareFirst BlueChoice will:

1. Send the non-insuring, custodial parent identification cards, claims forms, the applicable certificate of coverage or member contract, and any information needed to obtain benefits;

2. Allow the non-insuring, custodial parent or a provider of a Covered Service to submit a claim without the approval of the Subscriber; and

3. Provide benefits directly to:

   a) The non-insuring, custodial parent;

   b) The provider of the Covered Services, Covered Dental Services, or Covered Vision Services;

   c) The appropriate child support enforcement agency of any state or the District of Columbia; or

   d) The Department of Medical Assistance Services, as the payor of last resort.

B. Proof of Loss.

For Covered Services provided by Contracting Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacies, Members are not required to submit claims in order to obtain benefits.

For Covered Services provided by Non-Participating Providers, Non-Participating Dentists, Non-Contracting Vision Providers, and Non-Contracting Pharmacies, Members must furnish written proof of loss, or have the provider submit proof of loss, to CareFirst BlueChoice within two (2) years from the time proof is otherwise required. Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

CareFirst BlueChoice will honor claims submitted for Covered Services, Covered Dental Services or Covered Vision Services by any agency of the federal, state or local government that has the statutory authority to submit claims beyond the time limits established under this Agreement. These claims must be submitted to CareFirst BlueChoice before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst BlueChoice deems necessary to process the claims. CareFirst BlueChoice provides forms for this purpose.

C. Time of Payment of Claims. Except as provided in this paragraph, benefits payable will be paid not more than sixty (60) days after receipt of written proof of loss. Claims for services rendered after expiration of the first month of the grace period for recipients of Advance Payments of the Premium Tax Credit, as set forth in Sections 3.2B. and 4.2B.2., will be pended and will only be paid after the Subscriber makes payment of the Premium due. Any accrued benefits unpaid at the Member's death shall be paid to the Member's estate.

D. Claim Payments Made in Error. If CareFirst BlueChoice makes a claim payment to the Member in error, the Member is required to repay CareFirst the amount that was paid in error. If the Member has not repaid the full amount owed CareFirst BlueChoice and CareFirst BlueChoice makes a subsequent benefit payment to the Member, CareFirst may subtract the amount owed CareFirst BlueChoice from the subsequent payment to the Member. If CareFirst BlueChoice makes a claim payment to a provider in error, any overpayment shall be repaid by that provider and shall not be the responsibility of the Member.

E. Payment of Claims. Payments for Covered Services will be made by CareFirst BlueChoice directly to Contracting Vision, Participating and Preferred Dentists and Preferred Providers. If a Member receives Covered Services from Non-Contracting Vision or Non-Preferred Providers, CareFirst BlueChoice reserves the right to pay either the Member or the provider. If the Member has paid the health care provider for services rendered, benefits will be payable to the Member.

6.3 No Assignment. A Member cannot assign any benefits or payments due under this In-Network Agreement to any person, corporation or other organization, except as specifically provided by this In-Network Agreement or as required by law.

6.4 Legal Actions. A Member cannot bring any lawsuit against CareFirst BlueChoice to recover under this Agreement before the expiration of sixty (60) days after written proof of loss has been furnished, and not after three (3) years from the date that written proof of loss is required to be submitted to CareFirst.

6.5 Events Outside of CareFirst's Control. If CareFirst BlueChoice, for any reason beyond the control of CareFirst BlueChoice , is unable to provide the coverage promised in Agreement, CareFirst is liable for reimbursement of the expenses necessarily incurred by any Member in procuring the services through other providers, to the extent prescribed by law.

6.6 Physical Examination and Autopsy. CareFirst at its own expense, has the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

6.7 Identification Card. Any cards issued to Members are for identification only.

A. Possession of an identification card confers no right to benefits.

B. To be entitled to such benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable Premiums have actually been paid.

C. Any person receiving benefits to which he or she is not then entitled will be liable for the actual cost of such benefits.

6.8 Member Medical Records. It may be necessary to obtain Member medical records and information from hospitals, Skilled Nursing Facilities, physicians or other practitioners who treat the Member. When a Member becomes covered, the Member (and if the Member is legally incapable of giving such consent, the representative of such Member) automatically gives CareFirst BlueChoice permission to obtain and use such records and information, including medical records and information requested to assist CareFirst BlueChoice in determining benefits and eligibility of Members.

6.9 Member Privacy.. CareFirst BlueChoice shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable financial, medical or health related data. In that regard, CareFirst BlueChoice will not provide to unauthorized third parties any personally identifiable financial or medical information without the prior written authorization of the Member or parent/guardian of the Member or as otherwise permitted by law. Personal information, including email addresses and phone numbers, may be used and shared with other businesses who work with CareFirst BlueChoice to administer and/or provide benefits under this plan. Personal information, as described below, may also be used to notify enrollees about treatment options, health-related services, and/or coverage options. Enrollees may contact CareFirst BlueChoice to change the information used to communicate with them.

The more complete information health care providers have, the better they can meet the Members' health care needs. Sharing information and data with the Member's treating providers can lead to better coordinated care, help the Member get timely care, limit duplicative services, and help the provider better identify patients who would benefit most from care management and other care coordination programs.

How we use medical information to enhance or coordinate the Member's care — In order to administer the Member's health benefits, CareFirst BlueChoice receives claims data and other information from the Member's various providers of care regarding diagnoses, treatments, programs and services provided under your health plan. Individual treating providers, however, may not have access to information from the Member's other providers. When CareFirst BlueChoice has such information, it may share it with the Member's treating providers through secure, electronic means solely for purposes of enhancing or coordinating the Member's care and to assist in clinical decision making.

The Member may Opt-Out of information sharing by CareFirst BlueChoice for these care coordination purposes. The Member has the right to opt-out of the sharing of this information by CareFirst BlueChoice with his/her treating provider for care coordination purposes at any time. To opt-out, the Member must complete, sign and return the Opt-Out of Medical Information Sharing Form found at www.CareFirst BlueChoice.com/informationsharing. When the Member submits this form, the Member also ends participation in any of the programs listed in this Agreement that require the sharing of information to enhance or coordinate care. If the Member opts out, his/her treating providers will not have access to the data or information CareFirst BlueChoice has available to help enhance or coordinate his/her care.

6.10 CareFirst's Relationship to Providers. Health care providers, including Contracting Providers, Preferred Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers, are independent contractors or organizations and are related to CareFirst BlueChoice by contract only. Contracting Providers, Preferred Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers are not employees or agents of CareFirst BlueChoice and are not authorized to act on behalf of or obligate CareFirst BlueChoice with regard to interpretation of the terms of the In-Network Agreement, including eligibility of Members for coverage or entitlement to benefits. Contracting Providers, Preferred Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers maintain a provider-patient relationship with the Member and are solely responsible for the professional services they provide. CareFirst BlueChoice is not responsible for any acts or omissions, including those involving malpractice or wrongful death of Contracting Providers, Preferred Dentists, Contracting Vision Providers, Contracting Pharmacy Providers, or any other individual, facility or institution which provides services to Members or any employee, agent or representative of such providers.

6.11 Provider and Services Information. Listings of current Contracting Providers, Preferred Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers will be made available to Members at the time of enrollment. Updated listings are available to Members upon request. The listing of Contracting Providers, Preferred Dentists, Contracting Vision Providers and Contracting Pharmacy Providers is updated every fifteen (15) days on the CareFirst BlueChoice website (www.carefirst.com).

6.12 Administration of Agreement. CareFirst BlueChoice may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

6.13 Rules for Determining Dates and Times. The following rules will be used when determining dates and times:

A. All dates and times of day will be based on the dates and times applicable to the Washington, DC area, i.e., Eastern Standard Time or Eastern Daylight Savings Time, as applicable.

B. When reference is made to coverage being effective on a particular date, this means 12:01 a.m. on that date.

C. When reference is made to termination being effective on a particular date, this means 12:00 midnight on that date.

D. "Days" mean calendar days, including weekends, holidays, etc., unless otherwise noted.

E. "Year" refers to Calendar Year, unless a different benefit year basis is specifically stated.

6.14 Notices.

A. To the Member. Notice to Members will be sent via electronic mail, if the Member has consented to receive such notices via electronic mail, or by first class mail to the most recent address or electronic address for the Member in CareFirst BlueChoice's files. The notice will be effective on the date mailed, whether or not the Member in fact receives the notice or there is a delay in receiving the notice.

B. To CareFirst BlueChoice. When notice is sent to CareFirst BlueChoice, it must be sent by first class mail to:

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065

1. Notice will be effective on the date of receipt by CareFirst BlueChoice, unless

the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service.

2. CareFirst BlueChoice may change the address at which notice is to be given by giving written notice thereof to the Subscriber

6.15 Amendment Procedure. Amendments must be consistent with federal and state law. Except for Premium rate changes, CareFirst will amend this Agreement to implement modifications by mailing a notice of the amendment(s) to the Subscriber, via first class mail or electronically if the Member has consented to receive such notices via electronic mail. CareFirst BlueChoice will give at least sixty (60) days before the effective date of the amendment, unless the modification is mandated to conform with any applicable changes to state or federal law.

No agent or other person, except an officer of CareFirst BlueChoice, has the authority to waive any conditions or restrictions of the Agreement or to bind CareFirst BlueChoice by making any promise or representation or by giving or receiving any information. No change in the Agreement will be binding on CareFirst BlueChoice, unless evidenced by an amendment signed by an authorized representative of CareFirst BlueChoice.

6.16 Regulation of CareFirst. CareFirst BlueChoice is subject to regulation in the District of Columbia by the Department of Insurance, Securities and Banking pursuant to Title 31 of the District of Columbia Code and the District of Columbia Department of Health pursuant to Reorganization Plan No. 4 of 1996, as amended.

6.17 Records and Clerical Errors.

A. The Subscriber must furnish CareFirst BlueChoice with data and notifications required for coverage in the format approved by CareFirst BlueChoice .

B. Clerical errors in recording or reporting data will not alter this Agreement. Upon discovery, adjustments will be made to remedy the errors.

6.18 Applicable Law. This Agreement is entered into and is subject to the laws of the District of Columbia. All claims arising from this Agreement will be brought and maintained in the District of Columbia. The Academic Institution and Members consent to the jurisdiction of the District of Columbia for all actions arising from this Agreement.

6.19 Contestability of Agreement.

A. The Agreement may not be contested, except for nonpayment of Premium, after it has been in force for two (2) years from the date of issue;

B. Absent fraud, each statement made by an applicant or Member is considered to be a representation and not a warranty; and

C. A statement to effectuate coverage may not be used to avoid the coverage or reduce the benefits unless:

1. The statement is contained in a written instrument signed by the Subscriber or Member, and

2. A copy of the statement is given to the Subscriber or Member.

No statement contained within this provision precludes the assertion at any time of defenses based upon the person's ineligibility for coverage or upon other provisions in this Agreement.

6.20 Misstatement of Age. If the age of a Member has been misstated, all Premiums payable under this Agreement shall be equitably adjusted based on the Premium due based on the Member's correct age. If the correction of the Member's age results in an increase in the Premium due, the Subscriber shall pay CareFirst the increased Premium due by the next Premium Due Date after notification by CareFirst. If, due to the correction in the Member's age, a Subscriber has paid a

Premium or portion of a Premium not due, CareFirst BlueChoice 's liability is limited to a refund, on request, of any excess Premium paid for the period during which the Member's age was misstated.

6.21 Notice of Address Change. The Subscriber must notify CareFirst BlueChoice within fifteen (15) days of a change in residence or change in e-mail address, if the Member has consented to receive notices via electronic mail, or as soon as reasonably possible. Except in the case of a covered child who does not reside with the Subscriber, CareFirst BlueChoice is only responsible for mailing notices or correspondence to the last known physical address or e-mail address of the Subscriber.

6.22 Uniform Modification. CareFirst BlueChoice reserves the right to modify the In-Network Agreement at renewal if the modification is consistent with State law and is effective uniformly for all individuals with this product.

A. For purposes of this provision, modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered a uniform modification of coverage if:

1. The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement; and

2. The modification is directly related to the imposition or modification of the Federal or State requirement.

B. For purposes of this provision, other types of modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product meets all of the following criteria:

1. The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act);

2. The product is offered as the same product network type (for example, health maintenance organization, Preferred Provider organization, exclusive provider organization, point of service, or indemnity);

3. The product continues to cover at least a majority of the same service area;

4. Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act; and

5. The product provides the same covered benefits, except for any changes in benefits that cumulatively impact rate for any plan within the product within an allowable variation of ± 2 percentage points (not including changes pursuant to applicable Federal or State requirements).

6.23 Amendment Procedure. Except for Premium rate changes, CareFirst BlueChoice will amend this In-Network Agreement to implement modifications made pursuant to Section 6.22 by mailing a notice of the amendment(s) to the Subscriber, via first class mail or electronically if the Member has consented to receive such notices via electronic mail, before the date of the first day of the next annual open enrollment period.

If the material modification required by law is made at a time other than renewal, and if it affects the content of the summary of benefits and coverage, CareFirst BlueChoice will provide advance notice at least sixty (60) days before the effective date of the modification.

No agent or other person, except an officer of CareFirst BlueChoice, has the authority to waive any conditions or restrictions of the In-Network Agreement or to bind CareFirst BlueChoice by making any promise or representation or by giving or receiving any information. No change in

the In-Network Agreement will be binding on CareFirst BlueChoice, unless evidenced by an amendment signed by an authorized representative of CareFirst BlueChoice.

6.24 Conformity with State Statutes. Any provision of this Agreement, which, on its Effective Date, is in conflict with the statutes of the jurisdiction in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

SERVICE AREA

CareFirst BlueChoice's Service Area is a clearly defined geographic area in which CareFirst BlueChoice has arranged for the provision of health care services to be generally available and readily accessible to Members. CareFirst BlueChoice will provide the Member with a specific description of the Service Area at the time of enrollment.

The Service Area is as follows: the District of Columbia; the state of Maryland; in the Commonwealth of Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the areas of Fairfax and Prince William Counties in Virginia lying east of Route 123.

If a Member temporarily lives out of the Service Area (for example, if a Dependent goes to college in another state), the Member may be able to take advantage of the CareFirst BlueChoice Away From Home Program. This Program may allow a Member who resides out of the Service Area for an extended period of time to utilize the benefits of an affiliated Blue Cross and Blue Shield HMO. This Program is not coordination of benefits. **A Member who takes advantage of the Away From Home Program will be subject to the rules, regulations and plan benefits of the affiliated Blue Cross and Blue Shield HMO.** If the Member makes a permanent move, he/she does not have to wait until the Annual Open Enrollment Period to change plans. Please call [888-452-6403] or visit [www.bcbs.com] for more information on the Away from Home Program.

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

IN-NETWORK TERMINATION AND CONTINUATION PRIVILEGE AMENDMENT

This amendment is effective [_____]. If no date is shown, this amendment is effective on the effective date or renewal date of the Individual Enrollment Agreement to which this amendment is attached.

The definition of "Eligible Student" in Section 1 of the Evidence of Coverage is deleted and replaced with the following:

Eligible Student means an eligible, registered student of the Academic Institution, if:

1) the student is enrolled in the Student Health Plan; and,
2) the appropriate Premium for coverage has been paid.

Eligible Students must actively attend classes for at least the first thirty-one (31) days after the date for which coverage is purchased.

Section 4, Termination of Coverage, in the Individual Enrollment Agreement, is deleted and replaced with the following:

4.1 Termination of Agreement.

A. The Agreement shall terminate if Premium has not been paid in full by the Academic Institution.

B. The Subscriber may terminate the Agreement if coverage is no longer required by the Academic Institution.

C. Termination of Subscriber's enrollment at the Academic Institution. The Subscriber's and any Dependent's coverage will be terminated as follows if the Subscriber is no longer enrolled in the Academic Institution:

1. If termination of enrollment at the Academic Institution occurs after the first thirty-one (31) days of active attendance in enrolled classes, coverage will end at the end of the Benefit Period.

2. The Subscriber may request an earlier termination under Section 4.1C if no longer enrolled in the Academic Institution. If an earlier termination date is requested, Premiums will be refunded on a pro-rata basis, as applicable. The Subscriber is required to notify the Academic Institution of termination under Section 4.1C.3, and the Academic Institution is required to issue any applicable refund.

D. The Academic Institution must provide written notification to CareFirst BlueChoice of any such terminations under Section 4.1.A through 4.1.C. Termination shall be without prejudice to any claim originating prior to the effective date of the cancellation.

Section 4.7, Continuation Privilege, is added to Section 4, Termination of Coverage, in the Individual Enrollment Agreement.

4.7 Continuation Privilege

All covered students continuously covered under the Academic Institution's student health plan for at least [three (3) - six (6)] consecutive months and no longer meet the eligibility requirements under that policy are eligible to continue coverage for up to [three (3) - six (6)] consecutive months under the Academic Institution's student health plan in effect at the time of continuation. If a covered student is still eligible for continuation at the beginning of the next Benefit Period, the covered student must purchase coverage under the new student health plan chosen by the Academic Institution. Coverage under the new student health plan is subject to the rates and benefits selected by the Academic Institution for that Benefit Period. The covered student is responsible for any premium amounts due to the Academic Institution under the student health plan

This amendment is issued to be attached to the Individual Enrollment Agreement. This amendment does not change the terms and conditions of the Individual Enrollment Agreement, unless specifically stated herein.

CareFirst BlueChoice, Inc.

[Signature]

[Name]
[Title]

CareFirst BlueChoice, Inc.
[840 First Street, NE
Washington, DC 20065]

An independent licensee of the Blue Cross and Blue Shield Association.

FAMILY PLANNING BENEFITS EXCLUSIONS RIDER

This rider is issued by CareFirst BlueChoice to be attached to and become a part of the [In-Network] Student Health Plan Agreement. This rider is effective [_____] [on the effective date or renewal date of the [In-Network] Evidence of Coverage to which it is attached]. Notwithstanding any provision to the contrary in the [In-Network] Student Health Plan Agreement, the services stated in this rider are excluded from coverage at the Academic Institution's request.

[A. Religious Organization Exclusions

1. The Academic Institution has represented that it is a tax exempt religious organization that: (a) has the inculcation of religious values as its purpose; (b) primarily employs persons who share its religious tenets; and (c) primarily serves persons who share its religious tenets.

[2. Infertility Services are excluded from coverage.]

[3. Female contraceptive methods and counseling, including Prescription Drugs and devices are excluded from coverage.]

[4. Male contraceptive methods and counseling, including Prescription Drugs and devices are excluded from coverage.]]

[[B.] [Additional Exclusions][Services Excluded from Coverage]

[1. Elective Abortion]

[2. Infertility Services]

[3. Male contraceptive methods and counseling.]

[4. Male contraceptive Prescription Drugs and devices are excluded from coverage.]

[5. Sterilization procedures and any related services.]]

[C.] Notice

The Academic Institution is responsible for notifying its Subscribers in a reasonable and timely manner of these exclusions.

CareFirst BlueChoice, Inc.

[Signature]

_____

[Name]
[Title]

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20085
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

MORBID OBESITY SURGERY BENEFIT RIDER

This rider is effective on the effective date of the Individual Enrollment Agreement to which this Rider is attached.

The Individual Enrollment Agreement is amended to add the following:

I. Definitions

Body Mass Index (BMI) means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Morbid Obesity means:

A. a Body Mass Index that is greater than forty (40) kilograms per meter squared; or

B. a Body Mass Index equal to or greater than thirty-five (35) kilograms per meter squared with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

II. Surgical Treatment of Morbid Obesity. Benefits are provided for Medically Necessary surgical services for the treatment of Morbid Obesity, as determined by CareFirst BlueChoice.

A. The procedures must be recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity and consistent with guidelines approved by the National Institutes of Health.

B. Benefits are subject to the same terms and conditions as other Medically Necessary surgical procedures.

C. Surgical treatment of Morbid Obesity shall occur at a facility that is designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence and is designated by CareFirst BlueChoice.

III. The exclusion for surgical treatment for morbid obesity in the Evidence of Coverage is hereby deleted.

This rider is issued to be attached to the Individual Enrollment Agreement. This rider does not change the terms and conditions of the Individual Enrollment Agreement, unless specifically stated herein.

CareFirst BlueChoice, Inc.

[Signature]

_____

[Name]
[Title]

CareFirst BlueChoice, Inc.

[840 First Street, NE]
[Washington, DC 20065]
[(202) 479-8000]

An independent licensee of the Blue Cross and Blue Shield Association

2020 AMENDMENT

This amendment is effective [_____]. If no date is shown, this amendment is effective on the effective date or renewal date of the Individual Enrollment Agreement to which this amendment is attached.

TABLE OF CONTENTS

SECTION A - DEFINITIONS

The following definitions are added to Section 1, Definitions, in the Individual Enrollment Agreement.

Medication-Assisted Treatment (MAT) means Prescription Drugs used to treat Substance Use Disorders (Alcohol Use Disorder and opioid use disorder).

Substance Use Disorder means:

A. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or

B. Drug Use Disorder means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Substance Use Disorder Program means the CareFirst program for Members with a diagnosed Substance Use Disorder. The program includes ambulatory/outpatient detoxification, individual therapy, group therapy and medication assisted therapy.

SECTION B - BREAST CANCER SCREENING

Section 1.3.A.4., Breast Cancer Screening of the Description of Covered Services is amended to add the following

1. Breast Cancer Screening. Benefits will be provided for:
    a. At a minimum, breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.

    b. A baseline mammogram for women, including a 3-D mammogram.

c. An annual screening mammogram for women, including a 3-D mammogram.

d. Adjuvant breast cancer screening, including magnetic resonance imaging, ultrasound screening, or molecular breast imaging of the breast if:

2. A woman is believed to be at an increased risk for cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications of an increased risk for cancer as determined by a woman's physician or advanced practice registered nurse; or

3. A mammogram demonstrates a Class C or Class D Breast Density Classification.

4. Breast Density Classification means the four levels of breast density identified by the Breast Imaging Reporting and Data System established by the American College of Radiology.

SECTION C—MATERNITY SERVICES

Description of Covered Services, Section 1.5 C.2.c), Non-Preventive Services, is deleted and replaced with the following:

c) Non-preventive routine professional services rendered to the newborn during a covered hospitalization for delivery. A newborn Dependent child will be automatically covered for the first thirty-one (31) days following the child's birth. The Agreement describes the steps, if any, necessary to enroll a newborn Dependent child.

SECTION F – CLINICAL TRIAL PATIENT COST COVERAGE

The definition of "Qualified Individual" in Section 1.18, Clinical Trial Patient Cost Coverage, in the Description of Covered Services, is deleted and replaced with the following:

> Qualified Individual, as used in this section, means a Member who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to the prevention, early detection, treatment or monitoring of cancer, chronic disease, or other life-threatening illness, and the provider who recommended the Member for the clinical trial has concluded that the Member's participation in such trial is appropriate to prevent, detect early, treat or monitor cancer, chronic disease, or life-threatening illness, or the Member's participation is based on medical and scientific information.

The definition of "Routine Patient Costs" in Section 1.18, Clinical Trial Patient Cost Coverage, in the Description of Covered Services, is deleted and replaced with the following:

> Routine Patient Costs means the costs of all Medically Necessary items and health care services consistent with the Covered Services that are typically provided for a Qualified Individual who is not enrolled in a clinical trial that are incurred as a result of the item, device, or service being provided to the Qualified Individual for purposes of the clinical trial. Routine Patient Costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Section B, Covered Services, is deleted and replaced with the following:

B. Covered Services

1. Benefits for Routine Patient Costs to a Qualified Individual in a clinical trial will be provided if the Qualified Individual's participation in the clinical trial is the result of prevention, early detection, treatment or monitoring of cancer, chronic disease, or other life-threatening illness.

2. Coverage for Routine Patient Costs will be provided only if:

a) The item device or service is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or,

b) The item device or service is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening disease or condition, or chronic disease;

c) The item device or service is being provided in a federally funded or approved clinical trial approved by one of the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and quality, the Centers for Medicare and Medicaid Services, an NIH Cooperative Group, an NIH Center, the FDA in the form of an investigational new drug or device application, the federal Department of Defense, the federal Department of Veterans Affairs, the federal Department of Energy or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant,, or an institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH;

d) The item device or service is being provided under a drug trial that is exempt from the requirement of an investigational new drug application.

e) The facility and personnel providing the item device or service are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

3. Coverage is provided for the Routine Patient Costs incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Qualified Individual's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

SECTION E – MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

1. All references to "Substance Abuse" in the Individual Enrollment Agreement are deleted and replaced with "Substance Use Disorder".

2. Section 8, Mental Health and Substance Use Disorder Services, in the Description of Covered Services, is amended to add the following:

8.4 Substance Use Disorder Program. Program benefits will be provided for outpatient treatment of Substance Use Disorder in accordance with the Substance Use Disorder Program if:

A. The Member qualifies for the Substance Use Disorder Program, as determined by CareFirst BlueChoice.

B. The Member receives treatment from a recognized treatment center of excellence, as determined by CareFirst BlueChoice;and

C. Treatment is rendered though an intensive outpatient program (IOP) or an outpatient program at a recognized center of excellence as determined by CareFirst BlueChoice

SECTION F – PRESCRIPTION DRUGS

1. Section 11, Prescription Drugs, in the Description of Covered Services, is deleted and replaced with the following:

11.1 Covered Services
Benefits will be provided for Prescription Drugs, including but not limited to:

A. Any self-administered contraceptive drug or device, including a contraceptive drug and device on the Preventive Drug List, that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber. See Section 1.5.B, Contraceptive Methods and Counseling, for additional coverage of contraceptive drugs and devices.

B. Human growth hormones. Prior authorization is required.

C. Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber, including drugs listed in the Preventive Drug List.

Nicotine Replacement Therapy. Nicotine Replacement Therapy means a product, including a product on the Preventive Drug List that is used to deliver nicotine to an individual attempting to cease the use of tobacco products, approved by the FDA as an aid for the cessation of the use of tobacco products and obtained under a prescription written by an authorized prescriber. Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis.

D. Injectable medications that are self-administered and the prescribed syringes and needles.

E. Standard covered items such as insulin, glucagon and anaphylaxis kits.

F. Fluoride products.

G. Diabetic Supplies.

H. Oral chemotherapy drugs.

I. Hormone replacement therapy drugs.

11.2 Dispensing.

A. Non-Maintenance Drugs are limited to up to a thirty (30)-day supply.

B. Maintenance Drugs

1. Coverage for a Maintenance Drug is limited to a thirty (30) day supply for:

a) The first prescription; or,

b) A change in prescription.

2. The day supply for Maintenance Drugs will be based on the following:

a) the prescribed dosage;

b) standard manufacturer's package size, and

c) specified dispensing limits.

C. A Member may obtain up to a twelve (12) month supply of contraceptives at one time.

11.3 Mail Order Program. Except as provided in Section 11.4, all Members have the option of ordering Covered Prescription Drugs via mail order. A Member may obtain up to a twelve (12) month supply of contraceptives at one time.

11.4 Benefits for Specialty Pharmacy Prescription Drugs. Benefits will be provided for Covered Specialty Drugs only when obtained from a Pharmacy that is part of the Exclusive Specialty Pharmacy Network.

2. Section 13.1. D, General Provisions, Prescription Drug Coverage, is deleted and replaced with the following:

Prescription Drug Coverage.

1. Accessing the Prescription Drug Benefit Card Program.

a) Members may use his/her identification card to purchase Covered Prescription Drugs from Contracting Pharmacy Providers. If the Prescription Drug coverage includes a Deductible, the Member must pay the entire cost of the Covered Prescription Drug(s) until the Deductible is satisfied. Once the Deductible, if applicable, has been satisfied, the Member pays the appropriate Copayment or Coinsurance as stated in the Schedule of Benefits.

b) For Covered Prescription Drugs or diabetic supplies purchased from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst BlueChoice or its designee for reimbursement. In cases of Emergency Services or Urgent Care received outside of the Service Area, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee up to the amount of the total charge, minus any applicable Deductible, Copayment or Coinsurance. In all other cases, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee for the amount up to the Prescription Drug Allowed Benefit, minus any applicable Deductible, or Copayment or Coinsurance.

c) Except for Specialty Drugs, Members have the option of ordering Covered Prescription Drugs via mail order. The mail order program provides Members with a Pharmacy that has an agreement with CareFirst BlueChoice or its designee, to provide mail service for Covered Prescription Drugs in accordance with the terms of this provision. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance.

2. Additional Terms and Conditions

a) Members or health care providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Covered Prescription Drug in the Prescription Guidelines. A copy of the Prescription Guidelines is available to the Member or provider upon request.

b) Providers may substitute a Generic Drug for a Brand Name Drug. If there is no Generic Drug for the Brand Name Drug the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits for Preferred Brand Name Drugs or Non-Preferred Brand Name Drugs.

c) If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay

only the Non-Preferred Brand Name Drug Copayment or Coinsurance when Medically Necessary, as determined by CareFirst BlueChoice.

d) A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment or Coinsurance if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects.

e) When a Generic version of a Prescription Drug becomes available, the Brand Name Drug may be removed from the Formulary or moved to the Non-Preferred level.

f) Members must use 80% of a dispensed non-Maintenance Drug or Maintenance Drug in the manner prescribed before a refill of that prescription can be obtained.

g) The Member is responsible for obtaining prior authorization for Covered Prescription Drugs in the Prescription Guidelines when obtained from a non-Contracting Pharmacy Provider by calling the customer service telephone number listed on the identification card.

3. How to Obtain Prescription Drugs Not Included in the CareFirst BlueChoice Formulary.

The Member may request an exception for coverage of a Prescription Drug not contained on the CareFirst BlueChoice Formulary.

a) The Member, the Member's authorized representative or the Member's provider may request an exception based upon Medical Necessity by contacting the CareFirst BlueChoice at the telephone number located on the back of the Member's identification card.

b) An exception form should be submitted by the prescribing provider and returned to CareFirst BlueChoice. The prescribing provider may submit a letter of Medical Necessity for dispensing of the non-Covered Prescription Drug.

c) Upon review by the CareFirst BlueChoice, the prescribing provider and the Member or Member's representative will be notified.

i) If the request is approved then the Prescription Drug will be dispensed and the Member will be responsible for the Non-Preferred Brand Name Drug Copayment. If the Prescription Drug exception request is for a non-Formulary Specialty Drug and the exception is granted, then the Member will be responsible for the Non-Preferred Specialty Drug Copayment.

ii) If the exception request is denied, the denial shall be considered an Adverse Decision and may be appealed in accordance with the process outlined in the [Benefit Determination and Appeals Amendment].

In addition, if the exception request is denied, the Member, the Member's representative or the prescribing provider may submit an external exception request to CareFirst BlueChoice requiring that the original exception request and subsequent denial be reviewed by an independent review organization.

4. Timeframe for review and notification of outcome of exception request:

a) Urgent requests based on exigent circumstances from the Member's prescribing provider will be completed within twenty-four (24) hours.

For purposes of this provision, exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-Formulary

Prescription Drug.

b) Non-urgent requests will be completed within seventy-two (72) hours.

c) A request for an external review of the original exception request will be completed no later than twenty-four (24) hours after receipt of the request if the original exception request was urgent and seventy-two (72) hours following receipt of the request if the original exception request was non-urgent.

d) CareFirst BlueChoice shall provide coverage for the non-Formulary drug for the duration of the prescription (including refills) if coverage is granted under a standard exception request, or for the duration of the exigency if coverage is granted under an expedited exception request.

SECTION G - CARE SUPPORT PROGRAMS

The Description of Covered Services is amended to add the following:

Care Support Programs.

A. Definitions

Care Support Programs are health care and wellness programs designed to promote the collaborative process of assessment, planning, and facilitation, and advocacy for options and services to meet a Qualified Individual's health needs through communication and available resources to promote quality cost-effective outcomes. Care Support Programs include but are not limited to; care coordination, case management, condition specific support, enhanced monitoring, disease management, lifestyle coaching, health promotion and wellness programs.

Designated Provider means a provider or vendor contracted with CareFirst BlueChoice to provide services under CareFirst BlueChoice's Care Support Programs, and who has agreed to participate in Care Support Programs in cooperation with CareFirst BlueChoice for Members with complex chronic disease, high risk acute conditions or lifestyle behavior change.

Qualified Individual, as used in this provision, means a Member with certain conditions or complex health care needs, as determined by CareFirst BlueChoice, requiring care support and coordination of health services. The Member agrees to participate and comply with any and all elements in any given Care Support Program.

B. Covered Services

1. Care Support Programs are available to Qualified Individuals to manage the care of certain complex chronic or high-risk acute diseases when provided by Designated Providers or through CareFirst BlueChoice and are covered at no cost to the Qualified Individual. Covered Services provided under Care Support Programs can include but are not limited to: telemedicine services; case management services; expert consultation services; medication review services; medical equipment and monitoring services; and home health care services.

a) Covered Services received as part of a Care Support Program are subject to applicable contract limits, Deductibles, Copayments, and/or Coinsurance as stated in the Schedule of Benefits.

b) If the Qualified Individual's Evidence of Coverage is compatible with a federally-qualified Health Savings Account and the Qualified Individual has funded his/her HSA account during the Benefit Period, then the Qualified Individual will be responsible for any fees associated with the Member's participation in a Care Support Program until the annual Deductible has been met.

C. Exclusions and Limitations. Coverage will not be provided for the services listed in this amendment when rendered by non-Designated Providers.

SECTION H – EXCLUSIONS AND LIMITATIONS

Section 15.1GG Exclusions and Limitations, is deleted and replaced with the following exclusion:

15.GG	Services required solely for administrative purposes, for example, employment, insurance, foreign travel, school, camp admissions or participation in sports activities. [However, immunizations for foreign travel, when provided at the university health center, will be covered.]

Section 15.1, Exclusions and Limitations, is amended to add the following exclusion:

[15.11 Injury sustained while;

- Participating in any intercollegiate or professional sport, contest or competition.
- Traveling to or from such sport, contest or competition as a participant.
- Participating in any practice or conditioning program for such sport, contest or competition.]

[SECTION I – ACUPUNCTURE SERVICES

Section 1.11, Outpatient Therapeutic Treatment Services of the Description of Covered Services is amended to add the following:

H. Acupuncture Services. Benefits will be provided for Medically Necessary acupuncture services when provided by a provider licensed to perform such services.]

[SECTION J – MASSAGE THERAPY

Benefits will be provided for massage therapy when provided in a Student Health Center. Benefits will be provided regardless of Medical Necessity. Benefits are limited to two (2) visits per Benefit Period.]

This amendment is issued to be attached to the Individual Enrollment Agreement. This amendment does not change the terms and conditions of the Individual Enrollment Agreement, unless specifically stated herein.

CareFirst BlueChoice, Inc.

[Signature]

_____

[Name]
[Title]

CareFirst BlueChoice, Inc.

[840 First Street, NE]
[Washington, DC 20065]
[202-479-8000]

An independent licensee of the Blue Cross and Blue Shield Association

PRIOR AUTHORIZATION AMENDMENT

This amendment is effective [_____]. If no date is shown, this amendment is effective on the effective date or renewal date of the Individual Enrollment Agreement to which this amendment is attached.

All references to prior authorization requirements for medical services only in the Description of Covered Services are deleted.

Section [13.2], CareFirst BlueChoice Personnel Availability for Prior Authorization, in the Description of Covered Services, is deleted and replaced with the following:

[13.2] Prior Authorization

A. CareFirst BlueChoice requires prior authorization for certain diagnostics and medical treatment. When a Member seeks services from a Contracting Provider, the Contracting Provider is responsible for obtaining prior authorization. If the Contracting Provider fails to obtain prior authorization for Covered Services, the Member shall be held harmless.

B. Services Requiring Prior Authorization. Medical treatment received under the following categories of services may require prior authorization:

1. Hospital Inpatient Services; including ancillary services.
2. Inpatient Mental Health and Substance Use Disorder Services.
3. Inpatient rehabilitation.
4. Outpatient rehabilitation therapy (physical therapy, speech therapy, occupational therapy, spinal manipulation services and acupuncture).
5. Outpatient testing.
6. Outpatient surgery.
7. Facility based office visits.
8. Habilitative Services for adults.
9. Electroconvulsive Therapy (ECT).
10. Repetitive Transcranial Magnetic Stimulation (rTMS).
11. Organ and Tissue Transplants.
12. Controlled Clinical trials.
13. Air Ambulance Services (except for Medically Necessary air ambulance services in an emergency).
14. Skilled Nursing Facility.
15. Home Health Services.
16. Hospice Services.
17. Medical Devices and Supplies.
18. Imaging/Radiology.
19. Lab Testing.
20. Medications prescribed while in an inpatient or outpatient place of service.
21. Gender Reassignment Services.
22. Infusion Services.
23. Radiation Therapy.
24. Outpatient Chemotherapy.
25. Outpatient Dialysis
26. Genetic Testing.

27. Sleep Studies.

28. Pediatric Vision Services. It is the Member's responsibility to obtain the required prior authorization for Low Vision services and Medically Necessary Contact Lenses when these Covered Vision Services are obtained from a non-Contracting Vision Provider.

29. Human growth hormones and Prescription Drugs in the Prescription Guidelines. [It is the Member's responsibility to obtain the required prior authorization for human growth hormones and Prescription Drugs in the Prescription Guidelines when such Covered Services are obtained from a non-Contracting Pharmacy.]

See [https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page] for a list of specific Covered Services which require prior authorization.

C. See Section [13.1.C.5], Estimate of Eligible Benefits, and Section [13.1.B], Pediatric Vision Coverage, for requirements for Pediatric Dental Services and Pediatric Vision Services.

D. Prior authorization is not required for maternity admissions or any emergency services such as medical or Mental Health or Substance Use Disorder emergency admissions. Prior authorization is also not required for any Covered Services when Medicare is the primary insurer.

E. CareFirst BlueChoice reserves the right to make changes to the categories of services that are subject to utilization management requirements or to the procedures the Member and/or the providers must follow. CareFirst BlueChoice will notify the Member of these changes at least [forty-five (45)] days in advance.

F. CareFirst BlueChoice Personnel Availability for Prior Authorization. When CareFirst BlueChoice requires prior authorization for certain medical treatment as stated in this amendment, CareFirst BlueChoice will have personnel available to provide prior authorization at all times when such prior authorization is required.

This amendment is issued to be attached to the Individual Enrollment Agreement. This amendment does not change the terms and conditions of the Individual Enrollment Agreement, unless specifically stated herein.

CareFirst BlueChoice, Inc.

[Signature]

_____

[Name]
[Title]

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
(202) 479-8000

An independent licensee of the BlueCross and Blue Shield Association

ATTACHMENT C
IN-NETWORK SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Individual Enrollment Agreement.

Benefits for Covered Services, Covered Dental Services, and Covered Vision Services may be provided either under the In-Network Individual Enrollment Agreement or Out-of-Network Individual Enrollment Agreement. Benefits will not be provided for the same service or supply under both this In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. However, for certain services there are visit or other limitations. Where there is a benefit limitation, the benefit limitation is combined for both the In-Network Individual Enrollment Agreement and Out-of-Network Individual Enrollment Agreement.

CareFirst BlueChoice pays only for Covered Services, Covered Vision Services and Covered Dental Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Deductible, Copayment or Coinsurance. Services that are not listed in the In-Network Description of Covered Services, or are listed in the Exclusions and Limitations, are not Covered Services, Covered Vision Services or Covered Dental Services.

When determining the benefits a Member may receive, CareFirst BlueChoice considers all provisions and limitations in the Individual Enrollment Agreement as well as its medical policies. When these conditions of coverage are not met or followed, payments for benefits may be denied. Certain utilization management requirements will also apply. When these requirements are not met, payments may be reduced or denied.

[STUDENT HEALTH PLAN DEDUCTIBLE

The In-Network Deductible of **[Variable A]** per Member per Benefit Period applies to all Student Health Center Services.]

IN-NETWORK DEDUCTIBLE

[The In-Network Individual Benefit Period Deductible is **[Variable A]**.

The In-Network Family Benefit Period Deductible is [**Variable A]**.]

Individual Coverage: The Member must satisfy the In-Network Individual Deductible.

[Variable B]

[The In-Network Deductible and the Out-of-Network Deductible are separate amounts and do not contribute to one another.]

[The Benefit Period Deductible will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.]

The benefit chart below states whether a Covered Service is subject to the In-Network Deductible.

The following amounts may <u>not</u> be used to satisfy the Benefit Period Deductible:

- Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available.
- Charges in excess of the Allowed Benefit.
- Charges for services which are not covered under the Individual Enrollment Agreement or which exceed the maximum number of covered visits/days listed below.
- Charges for Covered Services not subject to the Deductible.

[• Charges for Prescription Drugs.]

- Charges for Pediatric Vision Services or Pediatric Dental Services.

[• Charges incurred under the Out-of-Network Individual Enrollment Agreement.]

IN-NETWORK OUT-OF-POCKET MAXIMUM

The In-Network Individual Benefit Period Out-of-Pocket Maximum is **[Variable C]**.

The In-Network Family Benefit Period Out-of-Pocket Maximum is **[Variable C]**.

Individual Coverage: The Member must meet the Individual Out-of-Pocket Maximum.

[Variable D].

[The In-Network Out-of-Pocket Maximum and the Out-of-Network Out-of-Pocket Maximum are separate amounts and do not contribute to one another.]

[The Benefit Period Out-of-Pocket Maximum will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.]

These amounts apply to the Benefit Period In-Network Out-of-Pocket Maximum:

- In-Network Copayments and Coinsurance for all Covered Services.
- [In-Network Benefit Period Deductible.]
- [Prescription Drug Deductible]
- In-Network Pediatric Dental Deductible and In-Network Coinsurance for Covered Dental Services.

When the Member has reached the Out-of-Pocket Maximum, no further Copayments, Coinsurance or Deductible will be required in that Benefit Period for Covered Services, Covered Dental Services and Covered Vision Services.

The following amounts may <u>not</u> be used to satisfy the Benefit Period Out-of-Pocket Maximum:

- Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available. If a Member selects a Brand Name Drug when a Generic Drug is available, manufacturer coupons and the difference between the price of the Brand Name Drug and the Generic Drug would not count towards the Out-of-Pocket Maximum. If the Brand Name Drug does not have a Generic Drug equivalent, then manufacturer coupons may count towards the Out-of-Pocket Maximum.
- Charges in excess of the Allowed Benefit, Prescription Drug Allowed Benefit, Vision Allowed Benefit and Pediatric Dental Allowed Benefit.
- Charges for services which are not covered under the Individual Enrollment Agreement or which exceed the maximum number of covered visits/days listed below.
- Charges incurred under the Out-of-Network Evidence of Coverage, except for Copayment, Coinsurance, and Deductible payments for essential health benefits provided by an Out-of-Network ancillary provider in an In-Network setting, as provided by 45 CFR § 156.230.

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.			
The Member is responsible for any applicable Deductible, Copayment or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider. The benefit chart below states whether a Covered Service is subject to the Member Copayment for Clinic Visits/ Outpatient Services rendered in a hospital, hospital clinic, or health care provider's office on a hospital campus ("Clinic Visit"). These providers may bill individually resulting in claims from both the hospital/facility and the physician or health care provider rendering care in the hospital/facility/clinic setting. It is the Member's responsibility to determine whether separate claims will be assessed. **[**The Deductible [and] [,] [Copayments] [or] [Coinsurance] will be waived for Covered Services rendered at the Student Health Center. Benefits for massage therapy provided at a Student Health Center are limited to two (2) visits per Benefit Period.] [Coverage at a Student Health Center is limited to Services available and provided at the Member's Student Health Center.]			
OUTPATIENT FACILITY, OFFICE AND PROFESSIONAL SERVICES			
Physician's Office	Services rendered by Specialists in the disciplines listed below will be treated as PCP visits for Member payment purposes. • General internal medicine; • Family practice medicine; • General pediatric medicine; or • Geriatric medicine.	PCP: **[Variable E]** Specialist: **[Variable E]** Clinic Visit: **[Variable E]**	PCP: **[Variable F]** Specialist: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.**]**
Outpatient Non-Surgical Services		PCP: **[Variable E]** Specialist: **[Variable E]** Clinic Visit: **[Variable E]**	PCP: **[Variable F]** Specialist: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.**]**
Laboratory Tests, X-Ray/Radiology Services, Specialty Imaging and Diagnostic Procedures			
Non-Preventive Laboratory Tests (independent non-hospital laboratory)		**[Variable E]**	**[Variable F]**
Non-Preventive Laboratory Tests (outpatient department of a hospital)		**[Variable E]**	**[Variable F]**

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.			
Non-Preventive X-Ray/Radiology Services (independent non-hospital facility)		**[Variable E]**	**[Variable F]**
Non-Preventive X-Ray/Radiology Services (outpatient department of a hospital)		**[Variable E]**	**[Variable F]**
Non-Preventive Specialty Imaging (independent non-hospital facility)		**[Variable E]**	**[Variable F]**
Non-Preventive Specialty Imaging (outpatient department of a hospital)		**[Variable E]**	**[Variable F]**
Non-Preventive Diagnostic Testing except as otherwise specified (in an independent non-hospital facility)		**[Variable E]**	**[Variable F]**
Non-Preventive Diagnostic Testing except as otherwise specified (in an outpatient department of a hospital)		**[Variable E]**	**[Variable F]**
Sleep Studies (Member's home)		**[Variable E]**	**[Variable F]**
Sleep Studies (office or freestanding facility)	Prior authorization is required.	**[Variable E]**	**[Variable F]**

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.			
Sleep Studies (outpatient department of a hospital)	Prior authorization is required.	**[Variable E]**	**[Variable F]**
Preventive Care – Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society or required by the Patient Protection and Affordable Care Act (PPACA), as well as 3-D mammogram and adjuvant breast cancer screening, as described in the Description of Covered Services			
Prostate Cancer Screening		No	No Copayment or Coinsurance
Colorectal Cancer Screening		No	No Copayment or Coinsurance
Breast Cancer Screening		No	No Copayment or Coinsurance
Pap Smear		No	No Copayment or Coinsurance
Human Papillomavirus Screening Test		No	No Copayment or Coinsurance
Preventive Laboratory Tests		No	No Copayment or Coinsurance
Preventive X-Ray/Radiology Services		No	No Copayment or Coinsurance
Preventive Specialty Imaging		No	No Copayment or Coinsurance
Preventive Diagnostic Testing (except as otherwise specified)		No	No Copayment or Coinsurance
Immunizations		No	No Copayment or Coinsurance
Well Child Care		No	No Copayment or Coinsurance
Adult Preventive Care		No	No Copayment or Coinsurance
Women's Preventive Services		No	No Copayment or Coinsurance
Office Visits for Treatment of Obesity		No	No Copayment or Coinsurance
Professional Nutritional Counseling and		No	No Copayment or Coinsurance

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.			
Medical Nutrition Therapy			
Treatment Services			
Family Planning			
Non-Preventive Gynecological Office Visits		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Contraceptive Counseling		**[Variable E]**	No Copayment or Coinsurance
Contraceptive Drugs and Devices	Coverage of self-administered contraceptive drugs and devices is provided under the Prescription Drugs benefit.	**[Variable E]**	No Copayment or Coinsurance
Insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs	Drug or device must be approved by the FDA as a contraceptive.	**[Variable E]**	No Copayment or Coinsurance
Elective Sterilization Services – Female Members	Benefits available to female Members with reproductive capacity only.	**[Variable E]**	No Copayment or Coinsurance
Maternity and Related Services			
Preventive Visit		No	No Copayment or Coinsurance
Non-Preventive Visit		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Professional Services for Delivery		**[Variable E]**	**[Variable F]**
Infertility Treatment			

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.			
Infertility Counseling and Testing		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Allergy Services			
Allergy Testing and Allergy Treatment		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Allergy Shots		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Rehabilitation Services			
Rehabilitative Physical Therapy	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Rehabilitative Occupational Therapy	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Rehabilitative Speech Therapy	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.			
Spinal Manipulation Services	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Habilitative Services for Children	Limited to Members under the age of 21.	[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Habilitative Services for Adults	Benefits available for Member age 21 and older. [Limited to **[Variable G]** visits per condition per Benefit Period for Physical Therapy, **[Variable G]** visits per condition per Benefit Period for Occupational Therapy and **[Variable G]** visits per condition per Benefit Period for Speech Therapy .]	[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Acupuncture		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic and there is a separate claim for the hospital/facility.]
Cardiac Rehabilitation	[Limited to 90 days per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Pulmonary Rehabilitation	Limited to one pulmonary rehabilitation program per lifetime combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

Other Treatment Services			
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation[,;and] pulmonary rehabilitation [and Infusion Services])		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.			
Blood and Blood Products		Benefits are available to the same extent as benefits provided for other [infusion] services	
Clinical Trials		Benefits are available to the same extent as benefits provided for other services	
Retail Health Clinic		**[Variable E]**	**[Variable F]**
Telemedicine Services	Benefits are available to the same extent as benefits provided for other services		
[Infusion Therapy			
Physician's Office		**[Variable E]**	**[Variable F]**
Free-Standing Infusion Center		**[Variable E]**	**[Variable F]**
Hospital Outpatient Department		**[Variable E]**	**[Variable F]**
Member's Home		**[Variable E]**	**[Variable F]]**
Outpatient Surgical Facility and Professional Services			
Surgical Care at an Ambulatory Care Facility		**[Variable E]**	**[Variable F]**
Outpatient Surgical Professional Services Provided at an Ambulatory Care Facility	**[Variable I]**	**[Variable E]**	**[Variable F]**
Surgical Care at an Outpatient Hospital Facility		**[Variable E]**	**[Variable F]**
Outpatient Surgical Professional Services Provided at an Outpatient Hospital	**[Variable I]**.	**[Variable E]**	**[Variable F]**
INPATIENT HOSPITAL SERVICES			
Inpatient Facility (medical or surgical condition, including	[Hospitalization solely for rehabilitation limited to ninety (90) days per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.]	**[Variable E]**	**[Variable F]**

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. **See Prior Authorization Amendment for Covered Services that require prior authorization.**			
maternity and rehabilitation)			
Inpatient Professional Services		**[Variable E]**	**[Variable F]**
Organ and Tissue Transplants	Except for corneal transplants and kidney transplants, prior authorization is required.	Benefits are available to the same extent as benefits provided for other services	
SKILLED NURSING FACILITY SERVICES			
Skilled Nursing Facility Services	[Limited to **[Variable J]**days per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.] F	**[Variable E]**	**[Variable F]**
HOME HEALTH SERVICES			
Home Health Services	F [Limited to ninety (90) visits per "episode of care" combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. A new episode of care begins if the Member does not receive Home Health Care for the same or a different condition for sixty (60) consecutive days.]	**[Variable E]**	**[Variable F]**
Postpartum Home Visits	Benefits are available to all Members.	**[Variable E]**	**[Variable F]**
HOSPICE SERVICES			
Inpatient Care	[Services limited to a maximum one hundred eighty (180) day hospice eligibility period] [Limited to sixty (60) days per hospice eligibility period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.]	**[Variable E]**	**[Variable F]**
Outpatient Care	[Services limited to a maximum one hundred eighty (180) day hospice eligibility period.]	**[Variable E]**	**[Variable F]**
Respite Care		**[Variable E]**	**[Variable F]**

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. **See Prior Authorization Amendment for Covered Services that require prior authorization.**			
	[Services limited to a maximum one hundred eighty (180) day hospice eligibility period.]		
Bereavement Services	Covered only if provided within ninety (90) days following death of the deceased.	**[Variable E]**	**[Variable F]**
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES			
Outpatient Services			
Office Visits		**[Variable E]**	**[Variable F]**
Outpatient Hospital Facility Services		**[Variable E]**	**[Variable F]**
Outpatient Professional Services Provided at an Outpatient Hospital Facility		**[Variable E]**	**[Variable F]**
Outpatient Psychological and Neuro-psychological Testing for Diagnostic Purposes		**[Variable E]**	**[Variable F]**
Methadone Maintenance		**[Variable E]**	**[Variable F]**
Partial Hospitalization		**[Variable E]**	**[Variable F]**
Professional Services at a Partial Hospitalization Facility		**[Variable E]**	**[Variable F]**
Inpatient Services			
Inpatient Facility Services		**[Variable E]**	**[Variable F]**
Inpatient Professional Services		**[Variable E]**	**[Variable F]**
EMERGENCY SERVICES AND URGENT CARE			
Urgent Care Facility	Limited to unexpected, urgently required services.	**[Variable E]**	**[Variable F]**
Hospital Emergency Room - Facility Services	Limited to Emergency Services or unexpected, urgently required services.	**[Variable E]**	**[Variable F]** [Waived if admitted]

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. **See Prior Authorization Amendment for Covered Services that require prior authorization.**			
Hospital Emergency Room – Professional Services	Limited to Emergency Services or unexpected, urgently required services.	**[Variable E]**	**[Variable F]**
Follow-Up Care after Emergency Surgery	Limited to Emergency Services or unexpected, urgently required services.	Benefits are available to the same extent as benefits provided for other services	
Ambulance Service		**[Variable E]**	**[Variable F]**
MEDICAL DEVICES AND SUPPLIES			
Durable Medical Equipment		**[Variable E]**	**[Variable F]**
Hair Prosthesis	Limited to one per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	**[Variable E]**	**[Variable F]**
Breastfeeding Equipment and Supplies		**[Variable E]**	**No Copayment or Coinsurance**
Diabetes Equipment	Coverage for Diabetes Supplies will also be provided under the Prescription Drug benefit.	**[Variable E]**	**[Variable F]**
Hearing Aids			
Hearing Aids	Limited to one hearing aid for each hearing-impaired ear every 36 months.	**[Variable E]**	**[Variable F]**
Hearing Aid Related Services		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
[WELLNESS BENEFIT			
[Health Risk Assessment		No	No Copayment or Coinsurance]
[Health Risk Assessment Feedback		No	No Copayment or Coinsurance]]

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• Except for Emergency Services and Urgent Care outside the Service Area, when Prescription Drugs are purchased from a non-Contracting Pharmacy Provider, charges above the Prescription Drug Allowed Benefit are a non-Covered Service. • If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment when Medically Necessary, as determined by CareFirst BlueChoice. • A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects. [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Prescription Drug Deductible.] • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines. [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Deductible stated in this Schedule of Benefits.]				
[Prescription Drug Deductible				
The Prescription Drug Deductible is [Variable K] per Member per Benefit Period.]				

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• Except for Emergency Services and Urgent Care outside the Service Area, when Prescription Drugs are purchased from a non-Contracting Pharmacy Provider, charges above the Prescription Drug Allowed Benefit are a non-Covered Service. • If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment when Medically Necessary, as determined by CareFirst BlueChoice. • A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects. [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Prescription Drug Deductible.] • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines. [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Deductible stated in this Schedule of Benefits.]				
Covered Prescription Drugs	Limited to a [30-34]-day supply per prescription or refill.	Preventive Drugs **[Variable E]** **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs: [Variable E]** Generic Drugs: **[Variable E]** Preferred Brand Name Drugs: **[Variable E]** Non-Preferred Brand Name Drugs: **[Variable E]**	**Preventive Drugs:** No Copayment or Coinsurance **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs: [Variable L]** per prescription or refill **Generic Drugs: [Variable L]** per prescription or refill **Preferred Brand Name Drugs: [Variable L]** per prescription or refill **Non-Preferred Brand Name Drugs; [Variable L]** per prescription or refill	

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• Except for Emergency Services and Urgent Care outside the Service Area, when Prescription Drugs are purchased from a non-Contracting Pharmacy Provider, charges above the Prescription Drug Allowed Benefit are a non-Covered Service. • If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment when Medically Necessary, as determined by CareFirst BlueChoice. • A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects. [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Prescription Drug Deductible.] • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines. [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Deductible stated in this Schedule of Benefits.]				
Maintenance Drugs	Limited to a [90-102]-day supply per prescription or refill. A Member may obtain up to a twelve (12) month supply of contraceptives at one time. <u>Maintenance Drug</u> means a Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.	Preventive Drugs **[Variable E]** **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs: [Variable E]** Generic Drugs: **[Variable E]** Preferred Brand Name Drugs: **[Variable E]** Non-Preferred Brand Name Drugs: **[Variable E]**	**Preventive Drugs :** No Copayment or Coinsurance **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs: [Variable M]** per prescription or refill **Generic Drugs: [Variable M]** per prescription or refill **Preferred Brand Name Drugs: [Variable M]** per prescription or refill **Non-Preferred Brand Name Drugs; [Variable M]** per prescription or refill

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
Covered Specialty Drugs	Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network. Coverage for Specialty Drugs will **not** be provided when a Member purchases Specialty Drugs from a Pharmacy **outside** of the Exclusive Specialty Pharmacy Network.	**[Variable E]**	**Preferred Specialty Drugs:** **[Variable L]** per fill for up to a [30-34]-day supply **[Variable M]** per fill for up to a [90-102]-day supply **Non-Preferred Specialty Drugs:** **[Variable L] p**er fill for up to a [30-34]-day supply **[Variable M]** per fill for up to a [90-102]-day supply	

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
Eye Examination	Limited to one per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance.
Lenses - Important note regarding Member Payments: "Basic" means spectacle lenses with no "add-ons" such as glare resistant treatment, ultraviolet coating, progressive lenses, transitional lenses and others which may result in additional costs to the Member.			
Basic Single vision	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Basic Bifocals	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Basic Trifocals	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Basic Lenticular	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Frames			
Frames	Limited to one frame per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
	Limited to frames contained in the Vision Care Designee's collection.		
Low Vision			
Low Vision Eye Examination	Prior authorization is required. Limited to one comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5-year period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	Expenses in excess of the Vision Allowed Benefit of **[Variable N]** are a non-Covered Vision Service
Follow-up care	Prior authorization required. Limited to four visits in any five-year period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	Expenses in excess of the Vision Allowed Benefit of **[Variable N]** are a non-Covered Vision Service
High-power Spectacles, Magnifiers and Telescopes	Prior authorization is required. Limited to a lifetime maximum of $1,200.	No	Expenses in excess of the Vision Allowed Benefit of **[Variable N]** are a non-Covered Vision Service
Contact Lenses			
Elective	Includes evaluation, fitting and follow-up fees. Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. Limited to contact lenses contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance
Medically Necessary	Prior authorization is required.	No	No Copayment or Coinsurance

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.		

Adult Vision – For Members age 19 and older			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
Eye Examination	Limited to one per Benefit Period.	No	**[Variable N]**

Pediatric Dental – Limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Dental Services up to the end of the Calendar Year in which the Member turns age 19.
Pediatric Dental Deductible
The In-Network Deductible of **[Variable K]** per Member per Benefit Period applies to all Class II, III, and IV Covered Dental Services.
Pediatric Dental Out-of-Pocket Maximum
Amounts paid by the Member for Covered Pediatric Dental Services will be applied to the In-Network Out-of-Pocket Maximum stated above. Once the In-Network Out-of-Pocket Maximum has been reached, the Member will no longer be required to pay any Deductible or Coinsurance.

SERVICE	LIMITATIONS	SUBJECT TO PEDIATRIC DENTAL DEDUCTIBLE?	MEMBER PAYS PREFERRED DENTIST
Class I Preventive & Diagnostic Services		**[Variable E]**	**[Variable O]**
Class II Basic Services		**[Variable E]**	**[Variable O]**
Class III Major Services – Surgical		**[Variable E]**	**[Variable O]**
Class IV Major Services – Restorative		**[Variable E]**	**[Variable O]**
Class V Orthodontic Services	Limited to Medically Necessary Orthodontia	**[Variable E]**	**[Variable O]**

CareFirst BlueChoice, Inc.
[Signature]

_____

[Name]
[Title]

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
(202) 479-8000

An independent licensee of the BlueCross and Blue Shield Association

ATTACHMENT C
IN-NETWORK SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Individual Enrollment Agreement.

Benefits for Covered Services, Covered Dental Services, and Covered Vision Services may be provided either under the In-Network Individual Enrollment Agreement or Out-of-Network Individual Enrollment Agreement. Benefits will not be provided for the same service or supply under both this In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. However, for certain services there are visit or other limitations. Where there is a benefit limitation, the benefit limitation is combined for both the In-Network Individual Enrollment Agreement and Out-of-Network Individual Enrollment Agreement.

CareFirst BlueChoice pays only for Covered Services, Covered Vision Services and Covered Dental Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Deductible, Copayment or Coinsurance. Services that are not listed in the In-Network Description of Covered Services, or are listed in the Exclusions and Limitations, are not Covered Services, Covered Vision Services or Covered Dental Services.

When determining the benefits, a Member may receive, CareFirst BlueChoice considers all provisions and limitations in the Individual Enrollment Agreement as well as its medical policies. When these conditions of coverage are not met or followed, payments for benefits may be denied. Certain utilization management requirements will also apply. When these requirements are not met, payments may be reduced or denied.

[STUDENT HEALTH PLAN DEDUCTIBLE

The In-Network Deductible of **[Variable A]** per Member per Benefit Period applies to all Student Health Center Services.]

IN-NETWORK DEDUCTIBLE

[The In-Network Individual Benefit Period Deductible is **[Variable A].**

The In-Network Family Benefit Period Deductible is **[Variable A]**.]

Individual Coverage: The Member must satisfy the In-Network Individual Deductible.

[Variable B]

[The In-Network Deductible and the Out-of-Network Deductible are separate amounts and do not contribute to one another.]

[The Benefit Period Deductible will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.]

The benefit chart below states whether a Covered Service is subject to the In-Network Deductible.

The following amounts may <u>not</u> be used to satisfy the Benefit Period Deductible:

- Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available.
- Charges in excess of the Allowed Benefit.
- Charges for services which are not covered under the Individual Enrollment Agreement or which exceed the maximum number of covered visits/days listed below.
- Charges for Covered Services not subject to the Deductible.

[• Charges for Prescription Drugs.]

- Charges for Pediatric Vision Services or Pediatric Dental Services.

[• Charges incurred under the Out-of-Network Individual Enrollment Agreement.]

IN-NETWORK OUT-OF-POCKET MAXIMUM
The In-Network Individual Benefit Period Out-of-Pocket Maximum is **[Variable C]**. The In-Network Family Benefit Period Out-of-Pocket Maximum is **[Variable C]**. **Individual Coverage:** The Member must meet the Individual Out-of-Pocket Maximum. **[Variable D]**. [The In-Network Out-of-Pocket Maximum and the Out-of-Network Out-of-Pocket Maximum are separate amounts and do not contribute to one another.] [The Benefit Period Out-of-Pocket Maximum will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.]
These amounts apply to the Benefit Period In-Network Out-of-Pocket Maximum: • In-Network Copayments and Coinsurance for all Covered Services. [• In-Network Benefit Period Deductible.] • Prescription Drug Deductible • In-Network Pediatric Dental Deductible and In-Network Coinsurance for Covered Dental Services. When the Member has reached the Out-of-Pocket Maximum, no further Copayments, Coinsurance or Deductible will be required in that Benefit Period for Covered Services, Covered Dental Services and Covered Vision Services. **The following amounts may <u>not</u> be used to satisfy the Benefit Period Out-of-Pocket Maximum:** • Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available. If a Member selects a Brand Name Drug when a Generic Drug is available, manufacturer coupons and the difference between the price of the Brand Name Drug and the Generic Drug would not count towards the Out-of-Pocket Maximum. If the Brand Name Drug does not have a Generic Drug equivalent, then manufacturer coupons may count towards the Out-of-Pocket Maximum. • Charges in excess of the Allowed Benefit, Prescription Drug Allowed Benefit, Vision Allowed Benefit and Pediatric Dental Allowed Benefit. • Charges for services which are not covered under the Individual Enrollment Agreement or which exceed the maximum number of covered visits/days listed below. • Charges incurred under the Out-of-Network Evidence of Coverage, except for Copayment, Coinsurance, and Deductible payments for essential health benefits provided by an Out-of-Network ancillary provider in an In-Network setting, as provided by 45 CFR § 156.230.

	BENEFITS			
SERVICE	**LIMITATIONS**	**Subject to Deductible**	**Student Health Center**	**In Network**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.				
The Member is responsible for any applicable Deductible, Copayment or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider. The benefit chart below states whether a Covered Service is subject to the Member Copayment for Clinic Visits/ Outpatient Services rendered in a hospital, hospital clinic, or health care provider's office on a hospital campus ("Clinic Visit"). These providers may bill individually resulting in claims from both the hospital/facility and the physician or health care provider rendering care in the hospital/facility/clinic setting. It is the Member's responsibility to determine whether separate claims will be assessed. **[**The Deductible [and] [,] [Copayments] [or] [Coinsurance] will be waived for Covered Services rendered at the Student Health Center. Benefits for massage therapy provided at a Student Health Center are limited to two (2) visits per Benefit Period.] [Coverage at a Student Health Center is limited to Services available and provided at the Member's Student Health Center.]				
	OUTPATIENT FACILITY, OFFICE AND PROFESSIONAL SERVICES			
Physician's Office	Services rendered by Specialists in the disciplines listed below will be treated as PCP visits for Member payment purposes. • General internal medicine; • Family practice medicine; • General pediatric medicine; or • Geriatric medicine.	**[Variable E]** Specialist: **[Variable E]** [Clinic Visit: **[Variable E]]**	PCP: [**Variable F]** Specialist: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.**]**	PCP: **[Variable F]** Specialist: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.**]**

Outpatient Non-Surgical Services		**[Variable E]** Specialist: **[Variable F]** **[Clinic Visit: [Variable E]]**	PCP: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or	PCP: **[Variable F]** Specialist: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.**]**

	BENEFITS			
SERVICE	**LIMITATIONS**	**Subject to Deductible**	**Student Health Center**	**In Network**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.				
Laboratory Tests, X-Ray/Radiology Services, Specialty Imaging and Diagnostic Procedures				
Non-Preventive Laboratory Tests (independent non-hospital laboratory)		**[Variable E]**	**[Variable F]**	**[Variable F]**
Non-Preventive Laboratory Tests (outpatient department of a hospital)		**[Variable E]**	**[Variable F]**	**[Variable F]**
Non-Preventive X-Ray/Radiology Services (independent non-hospital facility)		**[Variable E]**	**[Variable F]**	**[Variable F]**
Non-Preventive X-Ray/Radiology Services (outpatient department of a hospital)		**[Variable E]**	**[Variable F]**	**[Variable F]**
Non-Preventive Specialty Imaging (independent non-hospital facility)		**[Variable E]**	**[Variable F]**	**[Variable F]**
Non-Preventive Specialty Imaging (outpatient department of a hospital)		**[Variable E]**	**[Variable F]**	**[Variable F]**
Non-Preventive Diagnostic Testing except as otherwise specified (in an independent non-hospital facility)		**[Variable E]**	**[Variable F]**	**[Variable F]**
Non-Preventive Diagnostic Testing except		**[Variable E]**	**[Variable F]**	**[Variable F]**

	BENEFITS			
SERVICE	**LIMITATIONS**	**Subject to Deductible**	**Student Health Center**	**In Network**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.				
as otherwise specified (in an outpatient department of a hospital)				
Sleep Studies (Member's home)		**[Variable E]**	**[Variable F]**	**[Variable F]**
Sleep Studies (office or freestanding facility)	Prior authorization is required.	**[Variable E]**	**[Variable F]**	**[Variable F]**
Sleep Studies (outpatient department of a hospital)	Prior authorization is required.	**[Variable E]**	**[Variable F]**	**[Variable F]**
Preventive Care – Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society or required by the Patient Protection and Affordable Care Act (PPACA), as well as 3-D mammogram and adjuvant breast cancer screening, as described in the Description of Covered Services				
Prostate Cancer Screening		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Colorectal Cancer Screening		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Breast Cancer Screening		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Pap Smear		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Human Papillomavirus Screening Test		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Laboratory Tests		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive X-Ray/Radiology Services		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Specialty Imaging		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Diagnostic Testing (except as otherwise specified)		No	No Copayment or Coinsurance	No Copayment or Coinsurance

	BENEFITS			
SERVICE	**LIMITATIONS**	**Subject to Deductible**	**Student Health Center**	**In Network**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.				
Immunizations		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Well Child Care		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Adult Preventive Care		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Women's Preventive Services		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Office Visits for Treatment of Obesity		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Professional Nutritional Counseling and Medical Nutrition Therapy		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Treatment Services				
Family Planning				
Non-Preventive Gynecological Office Visits		Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	Professional: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Contraceptive Counseling		**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance
Contraceptive Drugs and Devices	Coverage of self-administered contraceptive drugs and devices is provided under the Prescription Drugs benefit.	**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance
Insertion or removal, and any Medically Necessary examination associated with	Drug or device must be approved by the FDA as a contraceptive.	**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance

BENEFITS				
SERVICE	**LIMITATIONS**	**Subject to Deductible**	**Student Health Center**	**In Network**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.				
the use of any contraceptive devices or drugs				
Elective Sterilization Services – Female Members	Benefits available to female Members with reproductive capacity only.	**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance
Maternity and Related Services				
Preventive Visit		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Non-Preventive Visit		**[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	Professional: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Professional Services for Delivery		**[Variable E]**	**[Variable F]**	**[Variable F]**

Infertility Treatment				
Infertility Counseling and Testing		Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	Professional: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Allergy Services				
Allergy Testing and Allergy Treatment		Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	Professional: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Allergy Shots		Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Rehabilitation Services				
Rehabilitative Physical Therapy	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

			hospital or hospital clinic.]	
Rehabilitative Occupational Therapy	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Rehabilitative Speech Therapy	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Spinal Manipulation Services	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Habilitative Services for Children	Limited to Members under the age of 21.	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

Habilitative Services for Adults	Benefits available for Member age 21 and older. [Limited to **[Variable G]** visits per condition per Benefit Period for Physical Therapy, **[Variable G]** visits per condition per Benefit Period for Occupational Therapy and **[Variable G]** visits per condition per Benefit Period for Speech Therapy .]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Acupuncture		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic and there is a separate claim for the hospital/facility.]	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic and there is a separate claim for the hospital/facility.]
Cardiac Rehabilitation	[Limited to 90 days per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

Pulmonary Rehabilitation	Limited to one pulmonary rehabilitation program per lifetime combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Other Treatment Services				
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation [and] pulmonary rehabilitation [and Infusion Services])		Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

Blood and Blood Products		Professional: **[Variable E]**	Benefits are available to the same extent as benefits provided for other [infusion] services	
Clinical Trials		Benefits are available to the same extent as benefits provided for other services		
Retail Health Clinic		**[Variable E]**	**[Variable F]**	**[Variable F]**
Telemedicine Services	Benefits are available to the same extent as benefits provided for other services			
Infusion Therapy				
Physician's Office		**[Variable E]**	**[Variable F]**	**[Variable F]**
Free-Standing Infusion Center		**[Variable E]**	**[Variable F]**	**[Variable F]**
Hospital Outpatient Department		**[Variable E]**	**[Variable F]**	**[Variable F]**
Member's Home		**[Variable E]**	**[Variable F]**	**[Variable F]**
Outpatient Surgical Facility and Professional Service				
Surgical Care at an Ambulatory Care Facility		**[Variable E]**	**[Variable F]**	**[Variable F]**
Outpatient Surgical Professional Services Provided at an Ambulatory Care Facility	**[Variable I]**	**[Variable E]**	**[Variable F]**	**[Variable F]**
Surgical Care at an Outpatient Hospital Facility		**[Variable E]**	**[Variable F]**	**[Variable F]**
Outpatient Surgical Professional Services Provided at an	**[Variable I]**	**[Variable E]**	**[Variable F]**	**[Variable F]**

Outpatient Hospital				
INPATIENT HOSPITAL SERVICES				
Inpatient Facility (medical or surgical condition, including maternity and rehabilitation)	[Hospitalization solely for rehabilitation limited to ninety (90) days per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.]	**[Variable E]**	**[Variable F]**	**[Variable F]**
Inpatient Professional Services		**[Variable E]**	**[Variable F]**	**[Variable F]**
Organ and Tissue Transplants	Except for corneal transplants and kidney transplants, prior authorization is required.	Benefits are available to the same extent as benefits provided for other services		
SKILLED NURSING FACILITY SERVICES				
Skilled Nursing Facility Services	[Limited to**[Variable J]** days per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.] F	**[Variable E]**	**[Variable F]**	**[Variable F]**
HOME HEALTH SERVICES				
Home Health Services	. [Limited to ninety (90) visits per "episode of care" combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. A new episode of care begins if the Member does	**[Variable E]**	**[Variable F]**	**[Variable F]**

	not receive Home Health Care for the same or a different condition for sixty (60) consecutive days.]			
Postpartum Home Visits	Benefits are available to all Members.	**[Variable E]**	**[Variable F]**	**[Variable F]**
HOSPICE SERVICES				
Inpatient Care	[Services limited to a maximum one hundred eighty (180) day hospice eligibility period] [Limited to sixty (60) days per hospice eligibility period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.]	**[Variable E]**	**[Variable F]**	**[Variable F]**
Outpatient Care	[Services limited to a maximum one hundred eighty (180) day hospice eligibility period.]	**[Variable E]**	**[Variable F]**	**[Variable F]**
Respite Care	[Services limited to a maximum one hundred eighty (180) day hospice eligibility period.]	**[Variable E]**	**[Variable F]**	**[Variable F]**
Bereavement Services	Covered only if provided within ninety (90) days following death of the deceased.	**[Variable E]**	**[Variable F]**	**[Variable F]**

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES				
Outpatient Services				
Office Visits		**[Variable E]**	**[Variable F]**	**[Variable F]**
Outpatient Hospital Facility Services		**[Variable E]**	**[Variable F]**	**[Variable F]**
Outpatient Professional Services Provided at an Outpatient Hospital Facility		**[Variable E]**	**[Variable F]**	**[Variable F]**
Outpatient Psychological and Neuro-psychological Testing for Diagnostic Purposes		**[Variable E]**	**[Variable F]**	**[Variable F]**
Methadone Maintenance		**[Variable E]**	**[Variable F]**	**[Variable F]**
Partial Hospitalization		**[Variable E]**	**[Variable F]**	**[Variable F]**
Professional Services at a Partial Hospitalization Facility		**[Variable E]**	**[Variable F]**	**[Variable F]**
Inpatient Services				
Inpatient Facility Services		**[Variable E]**	**[Variable F]**	**[Variable F]**
Inpatient Professional Services		**[Variable E]**	**[Variable F]**	**[Variable F]**
EMERGENCY SERVICES AND URGENT CARE				
Urgent Care Facility	Limited to unexpected, urgently required services.	**[Variable E]**	**[Variable F]**	**[Variable F]**
Hospital Emergency Room - Facility Services	Limited to Emergency Services or unexpected, urgently required services.	**[Variable E]**	**[Variable F]**	**[Variable F]** [Waived if admitted]
Hospital Emergency Room – Professional Services	Limited to Emergency Services or unexpected, urgently required services.	**[Variable E]**	**[Variable F]**	**[Variable F]**
Follow-Up Care after Emergency Surgery	Limited to Emergency Services or unexpected, urgently required services.	Benefits are available to the same extent as benefits provided for other services		

Ambulance Service		**[Variable E]**	**[Variable F]**	**[Variable F]**
MEDICAL DEVICES AND SUPPLIES				
Durable Medical Equipment		**[Variable E]**	**[Variable F]**	**[Variable F]**
Hair Prosthesis	Limited to one per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	**[Variable E]**	**[Variable F]**	**[Variable F]**
Breastfeeding Equipment and Supplies		**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance
Diabetes Equipment	Coverage for Diabetes Supplies will also be provided under the Prescription Drug benefit.	**[Variable E]**	**[Variable F]**	**[Variable F]**
Hearing Aids				
Hearing Aids	Limited to one hearing aid for each hearing-impaired ear every 36 months.	**[Variable E]**	**[Variable F]**	**[Variable F]**
Hearing Aid Related Services		**[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
[WELLNESS BENEFIT				
[Health Risk Assessment		**[Variable E]**	No	No Copayment or Coinsurance]
[Health Risk Assessment Feedback		**[Variable E]**	No	No Copayment or Coinsurance]]

PRESCRIPTION DRUGS					
		SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	STUDENT HEALTH CENTER	MEMBER PAYS	
SERVICE	LIMITATIONS			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
• Except for Emergency Services and Urgent Care outside the Service Area, when Prescription Drugs are purchased from a non-Contracting Pharmacy Provider, charges above the Prescription Drug Allowed Benefit are a non-Covered Service. • If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment when Medically Necessary, as determined by CareFirst BlueChoice. • A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects. [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Prescription Drug Deductible. • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Deductible stated in this Schedule of Benefits.]					
[Prescription Drug Deductible					
The Prescription Drug Deductible is [Variable K] per Member per Benefit Period.]					

PRESCRIPTION DRUGS					
		SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	STUDENT HEALTH CENTER	MEMBER PAYS	
SERVICE	LIMITATIONS			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
Covered Prescription Drugs	Limited to a [30-34]-day supply per prescription or refill.	Preventive Drugs: **[Variable E]** **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs: [Variable E]** Generic Drugs: **[Variable E]** Preferred Brand Name Drugs: **[Variable E]** Non-Preferred Brand Name Drugs: **[Variable E]**	Preventive Drugs: No Copayment or Coinsurance **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs: [Variable L]** Generic Drugs: **[Variable L]** per prescription or refill Preferred Brand Name Drugs: **[Variable L]** per prescription or refill Non-Preferred Brand Name Drugs: **[Variable L]** per prescription or refill]	Preventive Drugs: No Copayment or Coinsurance **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs: [Variable L]** Generic Drugs: **[Variable L]** per prescription or refill Preferred Brand Name Drugs: **[Variable L]** per prescription or refill Non-Preferred Brand Name Drugs: **[Variable L]** per prescription or refill	
Maintenance Drugs	Limited to a [90-102]-day supply per prescription or refill. A Member may obtain up to a twelve (12) month supply of contraceptives at one time. Maintenance Drug means a Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.	Preventive Drugs: **[Variable E]** **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs: [Variable E]** Generic Drugs: **[Variable E]** Preferred Brand Name Drugs: **[Variable E]** Non-Preferred Brand Name Drugs: **[Variable E]**	Preventive Drugs: No Copayment or Coinsurance **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs:: [Variable M]** Generic Drugs: **[Variable M]** per prescription or refill Preferred Brand Name Drugs: **[Variable M]** per prescription or refill Non-Preferred Brand Name Drugs: **[Variable M]** per prescription or refill	**Preventive Drugs:** No Copayment or Coinsurance **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs: [Variable M]** Generic Drugs: **[Variable M]** per prescription or refill Preferred Brand Name Drugs: **[Variable M]** per prescription or refill Non-Preferred Brand Name Drugs; **[Variable M]** per prescription or refill	

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	STUDENT HEALTH CENTER	MEMBER PAYS	
				CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS					
Covered Specialty Drugs	Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network. Coverage for Specialty Drugs will **not** be provided when a Member purchases Specialty Drugs from a Pharmacy **outside** of the Exclusive Specialty Pharmacy Network.	**[Variable E]**	**[Preferred Specialty Drugs: [Variable L]** per fill for up to a [30-34]-day supply **[Variable M]** per fill for up to a [90-102]-day supply **Non-Preferred Specialty Drugs: [Variable L] p**er fill for up to a [30-34]-day supply **[Variable M]** per fill for up to a [90-102]-day supply]	**Preferred Specialty Drugs:** **[Variable L]** per fill for up to a [30-34]-day supply **[Variable M]** per fill for up to a [90-102]-day supply **Non-Preferred Specialty Drugs:** **[Variable L] p**er fill for up to a [30-34]-day supply **[Variable M]** per fill for up to a [90-102]-day supply	

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
Eye Examination	Limited to one per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance.
Lenses - Important note regarding Member Payments: "Basic" means spectacle lenses with no "add-ons" such as glare resistant treatment, ultraviolet coating, progressive lenses, transitional lenses and others which may result in additional costs to the Member.			
Basic Single vision	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Basic Bifocals	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Basic Trifocals	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Basic Lenticular	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Frames			
Frames	Limited to one frame per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. Limited to frames contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
Low Vision			
Low Vision Eye Examination	Prior authorization is required. Limited to one comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5-year period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	Expenses in excess of the Vision Allowed Benefit of **[Variable N]** are a non-Covered Vision Service
Follow-up care	Prior authorization required. Limited to four visits in any five-year period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	Expenses in excess of the Vision Allowed Benefit of **[Variable N]** are a non-Covered Vision Service
High-power Spectacles, Magnifiers and Telescopes	Prior authorization is required. Limited to a lifetime maximum of $1,200.	No	Expenses in excess of the Vision Allowed Benefit of **[Variable N]** are a non-Covered Vision Service
Contact Lenses			
Elective	Includes evaluation, fitting and follow-up fees. Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. Limited to contact lenses contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance
Medically Necessary	Prior authorization is required. Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-	No	No Copayment or Coinsurance

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
	Network Individual Enrollment Agreement.		

Adult Vision – For Members age 19 and older			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE ?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
Eye Examination	Limited to one per Benefit Period.	No	**[Variable N]**

Pediatric Dental – Limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Dental Services up to the end of the Calendar Year in which the Member turns age 19.
Pediatric Dental Deductible
The In-Network Deductible of **[Variable K]** per Member per Benefit Period applies to all Class II, III, and IV Covered Dental Services.
Pediatric Dental Out-of-Pocket Maximum
Amounts paid by the Member for Covered Pediatric Dental Services will be applied to the In-Network Out-of-Pocket Maximum stated above. Once the In-Network Out-of-Pocket Maximum has been reached, the Member will no longer be required to pay any Deductible or Coinsurance.

SERVICE	LIMITATIONS	SUBJECT TO PEDIATRIC DENTAL DEDUCTIBLE?	MEMBER PAYS PREFERRED DENTIST
Class I Preventive & Diagnostic Services		**[Variable E]**	**[Variable O]**
Class II Basic Services		**[Variable E]**	**[Variable O]**
Class III Major Services – Surgical		**[Variable E]**	**[Variable O]**
Class IV Major Services – Restorative		**[Variable E]**	**[Variable O]**
Class V Orthodontic Services	Limited to Medically Necessary Orthodontia	**[Variable E]**	**[Variable O]**

CareFirst BlueChoice, Inc.
[Signature]

_____

[Name]
[Title]

State: District of Columbia **Filing Company:** CareFirst BlueChoice, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO
Product Name: 2020 DC CFBC Student Health Plan
Project Name/Number: /

Supporting Document Schedules

Satisfied - Item:	Submission Letter
Comments:	
Attachment(s):	DC CFBC SHP Submission Letter 12.13.19.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification Letter
Comments:	
Attachment(s):	DC CFBC Individual Readability Cert.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Explanation of Variations
Comments:	
Attachment(s):	DC-CFBC-SHP POS IN 2020 AMEND (8-20) EOV.pdf DC CFBC SHP CONT PRIV (8-20) eov.pdf DC-CFBC-SHP-POS IN IEA (8-20) eov.pdf DC-CFBC-SHP-AUTH AMEND-HMO (8-20) eov.pdf DC CFBC SHP POS INN_EOV_ (8-20).pdf DC CFBC SHP POS INN TO_EOV_(8-20).pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redline Versions
Comments:	
Attachment(s):	DC-CFBC-SHP POS IN 2020 AMEND (8-20).pdf DC CFBC SHP POS INN_IEA (8-20) Redline.pdf DC CFBC SHP POS INN TO_SOB_(8-20) Redline.pdf DC CFBC SHP POS INN_SOB_ (8-20) Redline.pdf
Item Status:	
Status Date:	

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
www.carefirst.com

December 13, 2019

Stephen C. Taylor, Commissioner
Department of Insurance, Securities and Banking
810 First Street, NE
Suite 701
Washington, DC 20002

RE: CareFirst BlueChoice, Inc.
NAIC Number: 96202

Form Numbers:
DC/CFBC-CF/SHP/AICA/POS (8/20)
DC/CFBC/SHP/POS IN/AIC (8/20)
DC/CFBC/SHP/ POS IN/IEA (8/20)
DC/CFBC/SHP CONT PRIV (8/20)
DC/CFBC/SHP/FAM PLAN (8/20)
DC/CFBC/SHP/MORBID OBESITY (R. 8/20)
DC/CFBC/SHP/POS IN SOB (8/20)
DC/CFBC/SHP/POS/IN/TO/ SOB (8/20)
DC/CFBC/SHP/2020 AMEND (8/20)
DC/CFBC/SHP/AUTH AMEND/HMO (8/20)

Dear Mr. Taylor:

Attached for your review and approval are copies of the above-referenced forms in their final versions. These forms will be used to create new non-grandfathered student health plans for the group market. The new rate information will be submitted under separate cover.

The intent of this filing is to secure approval of student health benefit plans that we wish to offer in the marketplace for the 2020-2021 academic year. Upon approval of the forms submitted under this filing, the following forms will be used to create our 2020-2021 student health plan **BlueChoice Advantage** product. For this product, the In-Network portion is underwritten by CareFirst BlueChoice, Inc., and the Out-of-Network portion is underwritten by Group Hospitalization and Medical Services, Inc.

Form Name	**Form Number**	**SERFF # and Approval Date**
Academic Institution Contract Application	DC/CFBC-CF/SHP/AICA/POS (8/20)	New submission
Academic Institution Contract	DC/CFBC/SHP/POS IN/AIC (8/20)	New submission
Student Health Plan Individual Enrollment Agreement	DC/CFBC/SHP/ POS IN/IEA (8/20)	New submission
Continuation of Coverage Rider	DC/CFBC/SHP CONT PRIV (8/20)	New submission
Family Planning Rider	DC/CFBC/SHP/FAM PLAN (8/20)	New submission
Morbid Obesity Rider	DC/CFBC/SHP/MORBID OBESITY (R. 8/20)	New submission

Schedule of Benefits – POS IN	DC/CFBC/SHP/POS IN SOB (8/20)	New submission
Schedule of Benefits – Triple Option	DC/CFBC/SHP/POS/IN/TO/ SOB (8/20)	New submission
2020 Amendment	DC/CFBC/SHP/2020 AMEND (8/20)	New submission
Prior Authorization Amendment	DC/CFBC/SHP/AUTH AMEND/HMO (8/20)	New submission
BlueCard Amendment	DC/CF/MEM/BLCRD (6/18)	SERFF Tracking # CFBC-131466359; Approved 4/23/18
Ancillary Services Amendment	DC/CF/ANCILLARY AMEND (10/12)	SERFF Tracking # CFBC-128657876; Approved 8/30/12
Patient Protection Disclosure Notice	DC/CF/PT PROTECT (9/10)	SERFF Tracking #CFBC-126871024; Approved 10/26/10
Benefit Determinations and Appeals Attachment	DC/GHMSI/DOL APPEAL (R. 1/17)	SERFF Tracking # CFBC-130737003; Approved 9/29/16
Description of Covered Services	DC/CFBC/SHP/POS IN/DOCS (8/18)	SERFF Tracking # CFBC-131225976; Approved 01-09-2018

The following forms will be taken out of production as of August 1, 2020. These forms were previously approved by the Department of Insurance, Securities and Banking on April 19, 2019 under SERFF filing number CFBC-131596406.

DC/CFBC/SHP/POS IN/AIC (8/19)
DC/CFBC-CF/SHP/AIA/POS (8/19)
DC/CFBC/SHP/POS (8/19)
DC/CFBC/SHP/POS IN/2019 Amend (8/19)
DC/CFBC/SHP/ POS IN/IEA (8/19)
DC/CFBC/SHP/TCCI (8/19)

The Readability Compliance Certification is included with these forms. The forms will attach to an Individual Enrollment Agreement with a Flesch Reading Ease score of 40 or more.

We appreciate your consideration of this matter and look forward to your acknowledgement and approval of these forms. If you have any questions, please contact me at (410) 872-3856 or via e-mail at Ashley.Carter@carefirst.com

Sincerely,

Ashley Carter
Contract Specialist
Contracting and Compliance

cc: Gina C. Harrison; Aisha Kane-Washington; Ryan Mihalic

READABILITY COMPLIANCE CERTIFICATION

NAME & ADDRESS OF INSURER: CareFirst BlueChoice, Inc.
840 First Street, NE, Washington, DC 20065
202-479-8000

I hereby certify that the policy form numbers listed below will attach to an evidence of coverage with a Flesch reading ease score above 40.0.

DC/CFBC-CF/SHP/AICA/POS (8/20)
DC/CFBC/SHP/POS IN/AIC (8/20)
DC/CFBC/SHP/ POS IN/IEA (8/20)
DC/CFBC/SHP CONT PRIV (8/20)
DC/CFBC/SHP/FAM PLAN (8/20)
DC/CFBC/SHP/MORBID OBESITY (R. 8/20)
DC/CFBC/SHP/POS IN SOB (8/20)
DC/CFBC/SHP/POS/IN/TO/ SOB (8/20)
DC/CFBC/SHP/2020 AMEND (8/20)
DC/CFBC/SHP/AUTH AMEND/HMO (8/20)

CareFirst BlueChoice, Inc. has reviewed the enclosed policy form and certifies that, to the best of its knowledge and belief, the form submitted is consistent and complies with the requirements of the District of Columbia Code, particularly §31-4725 and §31-4726(b)(2) of the District of Columbia Code.

Signed by Officer of the Insurer
Randolph S. Sergent
Vice President and Deputy General Counsel

12/13/2019
Date

CareFirst BlueChoice reserves the right to update or revise any company information such as telephone numbers, street addresses, email addresses, including signatures, names and titles contained herein, as necessary. Similarly, upon written notification from an applicable regulatory agency, CareFirst BlueChoice may update such agency information as directed. These changes will be made without refilling.

PAGE ONE
Heading
The address and phone number of the company should they change.

The bracketed text in the opening paragraph allows CareFirst to use a specific date or the effective/renewal date of the Individual Enrollment Agreement.

Table of Contents, Section I. Acupuncture
Bracketed text will be included when the Academic Institution elects to include a benefit for Acupuncture.

Table of Contents, Section J, Massage Therapy
Bracketed text will be included when the Academic Institution elects to include a benefit for massage therapy.

PAGE NINE
Section H, Exclusions and Limitations
Bracketed text related to section 15.1 GG. (immunizations) will be included when the Academic Institution has a university health center that will provide services for immunizations for foreign travel. Otherwise it will be omitted.

Bracketed text related to section 15.GG (Injury) will be omitted when the Academic Institution elects to exclude coverage for participation in intercollegiate or professional sport, contest or competition.

Section I, Acupuncture
Bracketed text will be included when the Academic Institution elects to include a benefit for Acupuncture.

Section J, Massage Therapy
Bracketed text will be included when the Academic Institution elects to include a benefit for massage therapy.

Signature
In the signature block at the bottom of the form, the variations will be for the signature, name and title of the CareFirst BlueChoice officer.

EXPLANATION OF VARIATIONS for Form Number DC/CFBC/SHP CONT PRIV (8/20)

Heading
The address and phone number of the company should they change.

Throughout the document
Section references [XX] may change to correspond with the correct section in the Student Health Plan Individual Enrollment Agreement.

Signature
The signature, name, and title of the company officer.

EXPLANATION OF VARIATIONS FOR FORM NO. DC/CF/SHP/POS/IN/IEA (8/20)

PAGE ONE

Heading

The address and phone number of the company should they change.

Subscriber Information

Bracketed text will be specific to the Subscriber.

Signature

The signature, name, and title of the company officer.

Page 29 & 30

Termination of Dependent Coverage

Bracketed text will be included when the Academic Institution selects when to terminate a Dependent Child

Heading
The address and phone number of the company.

Throughout the document
Section references [14.2]; [14.5]; [14.4] may change to correspond with the correct section in the Description of Covered Services.

Signature
The signature, name, and title of the company officer.

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS IN SOB (8/20)

Bracketed (**[ ]**) items indicate that the text may be omitted or that the variables indicated may be used in the marked section. If a bracketed item is omitted or a variation is used, the remaining provisions will be renumbered/re-lettered accordingly and appropriate adjustments made to alignment and formatting.

The address in the header is bracketed in case there is a change in address for CareFirst BlueChoice, Inc. The bracketed page numbers in the footer may vary according to where the document is placed in the Evidence of Coverage and according to the page number format used in the Evidence of Coverage. The variations for the signature, name, and title of the officer will contain the information for said officer.

Ranges of variable amounts have been included. At all times, contracts generated with this form will comply with federal and state mandated Member payment/cost-sharing requirements.

[STUDENT HEALTH CENTER DEDUCTIBLE…]	Service break will be included only when an Academic Institution that offers Student Health Center Services elects a benefit design that includes a separate Deductible for Student Health Center Services.
[The In-Network Family Benefit Period Deductible is **[Variable A].]**	Bracketed text will be omitted if the school elects not to include family coverage.
[The In-Network Individual Benefit Period Deductible ***]	Available variable for the last two rows under In-Network Deductible is: [There is no In-Network Deductible]
Variable A	$0 - $20,000 in increments of 5* ** For the In-Network Individual Deductible this amount shall not exceed the maximum cost-sharing amount for individual coverage established under Section 1302(c)(1) of the Patient Protection and Affordable Care Act.* *For the In-Network family Deductible, this amount will not exceed the maximum cost-sharing amount for family coverage established under Section 1302(c)(1) of the Patient Protection and Affordable Care Act. The range of $20,000 accommodates any revisions to the limits set by federal regulation for subsequent calendar years.*

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS IN SOB (8/20)

Variable B	This language will be used if the Deductible is stacked (separate): **Family Coverage:** Each Member can satisfy his/her own Deductible by meeting the Individual Deductible. In addition, eligible expenses for all covered Members can be combined to satisfy the Family Deductible. An individual family Member may not contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible has been met, this will satisfy the Deductible for all covered family Members. **OR** This language will be used if the Deductible is unstacked (aggregate): **Family Coverage**: The Deductible can be met entirely by one Member or by combining eligible expenses of two or more covered family Members. **There is no Individual Deductible with Family Coverage.** For Covered Services subject to the Deductible, the Family Deductible must be reached before CareFirst pays benefits for any Member who has Family Coverage. *** Under no circumstances will the In-Network Deductible for an individual for covered medical benefits and the separate Deductible for covered Prescription Drug benefits, if any, exceed the Out-of-Pocket Maximum limits set by federal regulation under Section 1302(c)(1) of the Affordable Care Act or any other limit set under applicable law.* Bracketed text will be omitted in it entirety if the school elect not to include family coverage
[The In-Network Deductible and the Out-of-Network Deductible are separate amounts and do not contribute to one another.]	The bracketed text will be included when the product design does not combine the In-Network and Out-of-Network eligible expenses
[The Benefit Period Deductible will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.]	The bracketed text will be included when the product design combines the In-Network and Out-of-Network eligible expenses to both the In-Network and Out-of-Network Deductibles.
[• Charges for Prescription Drugs.]	Bracketed language will be included when the product design includes a separate Prescription Drug Deductible or Prescription Drug benefits are not integrated with the Deductible.
• Charges for Pediatric Vision Services [or Pediatric Dental Services.]	Bracketed language will be included when the product design includes a separate Pediatric Dental Deductible or Covered Dental Service benefits are not integrated with the Deductible.
[Charges incurred under the Out-of-Network Individual Enrollment Agreement.]	The bracketed text will be included when the product design does not combine the In-Network and Out-of-Network eligible expenses

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS IN SOB (8/20)

[The In-Network Family Benefit Period Out-of-Pocket Maximum is **[Variable C]**.]	Bracketed text will be omitted if the school elects not to include family coverage.
Variable C	$0 - $40,000 in increments of 5* **For the In-Network Individual Out-of-Pocket Maximum this amount shall not exceed the maximum cost-sharing amount for individual coverage established under Section 1302(c)(1)*

	of the Patient Protection and Affordable Care Act. *For the In-Network family Out-of-Pocket Maximum, this amount will not exceed the maximum cost-sharing amount for family coverage established under Section 1302(c)(1) of the Patient Protection and Affordable Care Act. The range of $40,000 accommodates any revisions to the limits set by federal regulation for subsequent calendar years*
Variable D	This language will be used if the Out-of-Pocket Maximum is stacked (separate): **Family Coverage:** Each Member can satisfy his/her own Out-of-Pocket Maximum by meeting the Individual Out-of-Pocket Maximum. In addition, eligible expenses for all covered Members can be combined to satisfy the Family Out-of-Pocket Maximum. An individual family Member may not contribute more than the Individual Out-of-Pocket Maximum toward meeting the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum has been met, this will satisfy the Out-of-Pocket Maximum for all covered family Members. **OR** This language will be used if the Out-of-Pocket Maximum is unstacked (aggregate): **Family Coverage**: The Out-of-Pocket Maximum can be met entirely by one Member or by combining eligible expenses of two or more covered family Members. **There is no Individual Out-of-Pocket Maximum with Family Coverage.** The Family Out-of-Pocket Maximum must be reached before CareFirst waives payment of the listed amounts applying to the Out-of-Pocket Maximum. ***Under no circumstances will the In-Network Out-of-Pocket Maximum for an individual for covered medical benefits and the separate Out-of-Pocket Maximum for covered Prescription Drug benefits, if any, exceed the Out-of-Pocket Maximum limits set by federal regulation under Section 1302(c)(1) of the Affordable Care Act or any other limit set under applicable law.* Bracketed text will be omitted in its entirety if the school elects not to include family coverage.
[The In-Network Out-of-Pocket Maximum and the Out-of-Network Out-of-Pocket Maximum are separate amounts and do not contribute to one another.]	The bracketed text will be included when the product design does not combine the In-Network and Out-of-Network eligible expenses
[The Benefit Period Out-of-Pocket Maximum will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.]	The bracketed text will be included when the product design combines the In-Network and Out-of-Network eligible expenses to both the In-Network and Out-of-Network Out-of-Pocket Maximums.
[• Charges for Prescription Drugs.]	Bracketed language will be included when the product design includes a separate Prescription Drug Deductible.
[• In-Network Benefit Period Deductible.]	Bracketed language will be included when there is an In-Network Deductible.

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS IN SOB (8/20)

[• Prescription Drug Deductible.]	Bracketed text will be included when the plan design includes a separate Prescription Drug Deductible.
[The [Deductible] [and] [,] [Copayments] [or] [Coinsurance] will be waived for covered Services rendered at the Student Health Center.]	Bracketed text will be included or omitted based on whether the product design contains Copayments, Coinsurance or both as well as a Deductible for Student Health Centers.
[Coverage at a Student Health Center is limited to Services available and provided at the Member's Student Health Center. Benefits for massage therapy provided at a Student Health Center are limited to two (2) visits per Benefit Period.**]**	Bracketed text will be included only when an Academic Institution elects a benefit design where the cost-sharing for Student Health Center Services will mirror that of the Services if provided outside of the Student Health Center.
Variable E	Yes**OR** No
[Clinic Visit:. . .]	Bracketed language will be omitted when the product design does not include a separate cost share for Clinic Visit. . When the product design does not include a separate cost share for Clinic Visit, "Professional" will also be omitted from the "Subject to Deductible" column.

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS IN SOB (8/20)

Variable F	No Copayment or Coinsurance **OR** $0 - $2000 [per visit] OR [per test] OR [per study] OR [per admission] OR [per session] OR [per device] in increments of 5 **OR** 0 - 50% of the Allowed Benefit in increments of 5 **OR** $0 - $1000 per visit in increments of 5, and then 0 - 50% of the Allowed Benefit
[Sleep Studies (Member's home) ***, Sleep Studies (office or freestanding facility) ***. Sleep Studies (outpatient department of a hospital) ***]	The service breaks will be omitted when sleep studies are not differentiated from other Non-Preventive Diagnostic Testing except as otherwise specified.
Variable G	[30-100] in increments of 1. The standard is 30.

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS IN SOB (8/20)

[and . . . if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	Bracketed language will be omitted when the product design does not include a separate cost share for Clinic Visit.
[Prescription Drug Deductible .....per Member per Benefit Period.]	Service break will be included when the benefit plan design includes a separate Prescription drug Deductible.
Variable H	[20-100] in increments of 1. The standard is 20
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation[,; and][1] pulmonary rehabilitation [and Infusion Services][2])	[1] The "," will be used when Infusion Therapy service breaks are included. "and" will be included when the Infusion Therapy service breaks are omitted. [2] The bracketed text will be omitted when the service breaks for Infusion Therapy are omitted.
[Infusion Therapy Physician's Office ***, Free-Standing Infusion Center ***, Hospital Outpatient Department ***, Member's Home ***]	The service breaks will be omitted when infusion services are not differentiated from other Outpatient Therapeutic Treatment Services.
Blood and Bloood Products Benefits are available to the same extent as benefits provided for other [infusion] services	Bracketed text will be omitted when infusion services are not differentiated from other Outpatient Therapeutic Treatment Services.
Variable I	Routine/Screening Colonoscopy is not subject to the [Copayment; Coinsurance] [and] [Deductible] Use of the bracketed text is dependent on values listed for Variables D & F
Variable J	[100] [120] [150] [180] The standard is 100.
Hospital Emergency Room - Facility Services [Waived if admitted]	Bracketed text will be omitted when the Member cost share is a Coinsurance.

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS IN SOB (8/20)

Limited to a [30]-day supply per prescription or refill.	30-34 days in increments of 1. The standard is 30.
Limited to a [90]-day supply per prescription or refill	90-102 in increments of 1. The standard is 90
[30]-day supply of a non-Maintenance Drug	30-34 days in increments of 1
[90]-day supply of a Maintenance Drug	90-102 in increments of 1
Variable M	$[0 - 450] in increments of 5 **OR** [0-50]% of the Prescription Drug Allowed Benefit in increments of 5 [not to exceed $450] in increments of 5* * *Bracketed text will be included when the variable is used with Specialty Drugs.*
Variable N	$[0 - 1,000] in increments of 5
[Pediatric Dental Deductible . . . Covered Dental Services.]	Service break will be included when the benefit plan design includes a separate Pediatric Dental Deductible.
Variable O	No Coinsurance **OR** No Copayment**OR** [0 – 50]% of Pediatric Dental Allowed Benefit in increments of 5

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS IN SOB (8/20)

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS/IN/TO/SOB (8/20)

Bracketed (**[ ]**) items indicate that the text may be omitted or that the variables indicated may be used in the marked section. If a bracketed item is omitted or a variation is used, the remaining provisions will be renumbered/re-lettered accordingly and appropriate adjustments made to alignment and formatting.

The address in the header is bracketed in case there is a change in address for CareFirst BlueChoice, Inc. The bracketed page numbers in the footer may vary according to where the document is placed in the Evidence of Coverage and according to the page number format used in the Evidence of Coverage. The variations for the signature, name, and title of the officer will contain the information for said officer.

Ranges of variable amounts have been included. At all times, contracts generated with this form will comply with federal and state mandated Member payment/cost-sharing requirements.

[STUDENT HEALTH CENTER DEDUCTIBLE…]	Service break will be included only when an Academic Institution that offers Student Health Center Services elects a benefit design that includes a separate Deductible for Student Health Center Services.
[The In-Network Family Benefit Period Deductible is **[Variable A].]**	Bracketed text will be omitted if the school elects not to include family coverage.
[The In-Network Individual Benefit Period Deductible ***]	Available variable for the last two rows under In-Network Deductible is: [There is no In-Network Deductible]
Variable A	$0 - $20,000 in increments of 5* ** For the In-Network Individual Deductible this amount shall not exceed the maximum cost- sharing amount for individual coverage established under Section 1302(c)(1) of the Patient Protection and Affordable Care Act.* *For the In-Network family Deductible, this amount will not exceed the maximum cost-sharing amount for family coverage established under Section 1302(c)(1) of the Patient Protection and Affordable Care Act. The range of $20,000 accommodates any revisions to the limits set by federal regulation for subsequent calendar years.*

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS/IN/TO/SOB (8/20)

Variable B	This language will be used if the Deductible is stacked (separate): **Family Coverage:** Each Member can satisfy his/her own Deductible by meeting the Individual Deductible. In addition, eligible expenses for all covered Members can be combined to satisfy the Family Deductible. An individual family Member may not contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible has been met, this will satisfy the Deductible for all covered family Members. **OR** This language will be used if the Deductible is unstacked (aggregate): **Family Coverage**: The Deductible can be met entirely by one Member or by combining eligible expenses of two or more covered family Members. **There is no Individual Deductible with Family Coverage.** For Covered Services subject to the Deductible, the Family Deductible must be reached before CareFirst pays benefits for any Member who has Family Coverage. *** Under no circumstances will the In-Network Deductible for an individual for covered medical benefits and the separate Deductible for covered Prescription Drug benefits, if any, exceed the Out-of-Pocket Maximum limits set by federal regulation under Section 1302(c)(1) of the Affordable Care Act or any other limit set under applicable law.* Bracketed text will be omitted in it entirety if the school elect not to include family coverage
[The In-Network Deductible and the Out-of-Network Deductible are separate amounts and do not contribute to one another.]	The bracketed text will be included when the product design does not combine the In-Network and Out-of-Network eligible expenses
[The Benefit Period Deductible will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.]	The bracketed text will be included when the product design combines the In-Network and Out-of-Network eligible expenses to both the In-Network and Out-of-Network Deductibles.
[• Charges for Prescription Drugs.]	Bracketed language will be included when the product design includes a separate Prescription Drug Deductible or Prescription Drug benefits are not integrated with the Deductible.
• Charges for Pediatric Vision Services [or Pediatric Dental Services.]	Bracketed language will be included when the product design includes a separate Pediatric Dental Deductible or Covered Dental Service benefits are not integrated with the Deductible.

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS/IN/TO/SOB (8/20)

[Charges incurred under the Out-of-Network Individual Enrollment Agreement.]	The bracketed text will be included when the product design does not combine the In-Network and Out-of-Network eligible expenses
[The In-Network Family Benefit Period Out-of-Pocket Maximum is **[Variable C]**.]	Bracketed text will be omitted if the school elects not to include family coverage.
Variable C	$0 - $40,000 in increments of 5* **For the In-Network Individual Out-of-Pocket Maximum this amount shall not exceed the*

	maximum cost-sharing amount for individual coverage established under Section 1302(c)(1) of the Patient Protection and Affordable Care Act. *For the In-Network family Out-of-Pocket Maximum, this amount will not exceed the maximum cost-sharing amount for family coverage established under Section 1302(c)(1) of the Patient Protection and Affordable Care Act. The range of $40,000 accommodates any revisions to the limits set by federal regulation for subsequent calendar years*
Variable D	This language will be used if the Out-of-Pocket Maximum is stacked (separate): **Family Coverage:** Each Member can satisfy his/her own Out-of-Pocket Maximum by meeting the Individual Out-of-Pocket Maximum. In addition, eligible expenses for all covered Members can be combined to satisfy the Family Out-of-Pocket Maximum. An individual family Member may not contribute more than the Individual Out-of-Pocket Maximum toward meeting the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum has been met, this will satisfy the Out-of-Pocket Maximum for all covered family Members. **OR** This language will be used if the Out-of-Pocket Maximum is unstacked (aggregate): **Family Coverage**: The Out-of-Pocket Maximum can be met entirely by one Member or by combining eligible expenses of two or more covered family Members. **There is no Individual Out-of-Pocket Maximum with Family Coverage.** The Family Out-of-Pocket Maximum must be reached before CareFirst waives payment of the listed amounts applying to the Out-of-Pocket Maximum. ***Under no circumstances will the In-Network Out-of-Pocket Maximum for an individual for covered medical benefits and the separate Out-of-Pocket Maximum for covered Prescription Drug benefits, if any, exceed the Out-of-Pocket Maximum limits set by federal regulation under Section 1302(c)(1) of the Affordable Care Act or any other limit set under applicable law.* Bracketed text will be omitted in its entirety if the school elects not to include family coverage.
[The In-Network Out-of-Pocket Maximum and the Out-of-Network Out-of-Pocket Maximum are separate amounts and do not contribute to one another.]	The bracketed text will be included when the product design does not combine the In-Network and Out-of-Network eligible expenses
[The Benefit Period Out-of-Pocket Maximum will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.]	The bracketed text will be included when the product design combines the In-Network and Out-of-Network eligible expenses to both the In-Network and Out-of-Network Out-of-Pocket Maximums.

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS/IN/TO/SOB (8/20)

[• In-Network Benefit Period Deductible.]	Bracketed language will be included when there is an In-Network Deductible.
[• Prescription Drug Deductible.]	Bracketed text will be included when the plan design includes a separate Prescription Drug Deductible.
[The [Deductible] [and] [,] [Copayments] [or] [Coinsurance] will be waived for covered Services rendered at the Student Health Center.]	Bracketed text will be included or omitted based on whether the product design contains Copayments, Coinsurance or both as well as a Deductible for Student Health Centers.
[Coverage at a Student Health Center is limited to Services available and provided at the Member's Student Health Center. Benefits for massage therapy provided at a Student Health Center are limited to two (2) visits per Benefit Period.**]**	Bracketed text will be included only when an Academic Institution elects a benefit design where the cost-sharing for Student Health Center Services will mirror that of the Services if provided outside of the Student Health Center.

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS/IN/TO/SOB (8/20)

Variable E	Yes **OR** No
[Clinic Visit:. . .]	Bracketed language will be omitted when the product design does not include a separate cost share for Clinic Visit. When the product design does not include a separate cost share for Clinic Visit, "Professional" will also be omitted from the "Subject to Deductible" column.

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS/IN/TO/SOB (8/20)

Variable F	No Copayment or Coinsurance **OR** $0 - $2000 [per visit] OR [per test] OR [per study] OR [per admission] OR [per session] OR [per device] in increments of 5 **OR** 0 - 50% of the Allowed Benefit in increments of 5 **OR** $0 - $1000 per visit in increments of 5, and then 0 - 50% of the Allowed Benefit
[Sleep Studies (Member's home) ***, Sleep Studies (office or freestanding facility) ***. Sleep Studies (outpatient department of a hospital) ***]	The service breaks will be omitted when sleep studies are not differentiated from other Non-Preventive Diagnostic Testing except as otherwise specified.
Variable G	[30-100] in increments of 1. The standard is 30.
[and . . . if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	Bracketed language will be omitted when the product design does not include a separate cost share for Clinic Visit.
[Prescription Drug Deductible . . . per Member per Benefit Period.]	Service break will be included when the benefit plan design includes a separate Prescription drug Deductible.

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS/IN/TO/SOB (8/20)

Variable H	[20-100] in increments of 1. The standard is 20
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation[,; and][1] pulmonary rehabilitation [and Infusion Services][2])	[1] The "," will be used when Infusion Therapy service breaks are included. "and" will be included when the Infusion Therapy service breaks are omitted. [2] The bracketed text will be omitted when the service breaks for Infusion Therapy are omitted.
[Infusion Therapy Physician's Office ***, Free-Standing Infusion Center ***, Hospital Outpatient Department ***, Member's Home ***]	The service breaks will be omitted when infusion services are not differentiated from other Outpatient Therapeutic Treatment Services.
Blood and Blood Products Benefits are available to the same extent as benefits provided for other [infusion] services	Bracketed text will be omitted when infusion services are not differentiated from other Outpatient Therapeutic Treatment Services.
Variable I	Routine/Screening Colonoscopy is not subject to the [Copayment; Coinsurance] [and] [Deductible] Use of the bracketed text is dependent on values listed for Variables D & F
Variable J	[100] [120] [150] [180] The standard is 100.
Hospital Emergency Room - Facility Services [Waived if admitted]	Bracketed text will be omitted when the Member cost share is a Coinsurance.
Limited to a [30]-day supply per prescription or refill.	30-34 days in increments of 1. The standard is 30.

EXPLANATION OF VARIATIONS
FOR FORM NO. DC/CFBC/SHP/POS/IN/TO/SOB (8/20)

Limited to a [90]- day supply per prescription or refill	90-102 in increments of 1. The standard is 90
[30]-day supply of a non-Maintenance Drug	30-34 days in increments of 1
[90]-day supply of a Maintenance Drug	90-102 in increments of 1
Variable M	$[0 - 450] in increments of 5 **OR** [0-50]% of the Prescription Drug Allowed Benefit in increments of 5 [not to exceed $450] in increments of 5* * *Bracketed text will be included when the variable is used with Specialty Drugs*
Variable N	$[0 - 1,000] in increments of 5
[Pediatric Dental Deductible . . . Covered Dental Services.]	Service break will be included when the benefit plan design includes a separate Pediatric Dental Deductible.
Variable O	No Coinsurance **OR** No Copayment **OR** [0 – 50]% of Pediatric Dental Allowed Benefit in increments of 5

CareFirst BlueChoice, Inc.
[840 First Street, NE]
[Washington, DC 20065]
[(202) 479-8000]

An independent licensee of the Blue Cross and Blue Shield Association

2020~~19~~ AMENDMENT

This amendment is effective [_____]. If no date is shown, this amendment is effective on the effective date or renewal date of the Individual Enrollment Agreement to which this amendment is attached.

TABLE OF CONTENTS

SECTION A - DEFINITIONS
The following definitions are added to Section 1, Definitions, in the Individual Enrollment Agreement.

Medication-Assisted Treatment (MAT) means Prescription Drugs used to treat Substance Use Disorders (Alcohol Use Disorder and opioid use disorder).

Substance Use Disorder means:

A. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or

B. Drug Use Disorder means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Substance Use Disorder Program means the CareFirst program for Members with a diagnosed Substance Use Disorder. The program includes ambulatory/outpatient detoxification, individual therapy, group therapy and medication assisted therapy.

~~**SECTION A - ENHANCED MONITORING PROGRAM**~~

~~Section 1, Outpatient Facility, Office, and Professional Services, in the Description of Covered Services, is amended to add the following:~~

~~Enhanced Monitoring Program (EMP). Program benefits will be provided for the medical equipment and monitoring services provided to a Member who qualifies under the EMP as determined by CareFirst BlueChoice.~~

SECTION B - BREAST CANCER SCREENING

Section 1.3.A.4., Breast Cancer Screening of the Description of Covered Services is amended to add the following

1. Breast Cancer Screening. Benefits will be provided for:
   a. At a minimum, breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.

   b. A baseline mammogram for women, including a 3-D mammogram.

   c. An annual screening mammogram for women, including a 3-D mammogram.

   d. Adjuvant breast cancer screening, including magnetic resonance imaging, ultrasound screening, or molecular breast imaging of the breast if:

2. A woman is believed to be at an increased risk for cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications of an increased risk for cancer as determined by a woman's physician or advanced practice registered nurse; or

3. A mammogram demonstrates a Class C or Class D Breast Density Classification.

4. Breast Density Classification means the four levels of breast density identified by the Breast Imaging Reporting and Data System established by the American College of Radiology.

SECTION C—MATERNITY SERVICES

Description of Covered Services, Section 1.5 C.2.c), Non-Preventive Services, is deleted and replaced with the following:

c) Non-preventive routine professional services rendered to the newborn during a covered hospitalization for delivery. A newborn Dependent child will be automatically covered for the first thirty-one (31) days following the child's birth. The Agreement describes the steps, if any, necessary to enroll a newborn Dependent child.

SECTION F – CLINICAL TRIAL PATIENT COST COVERAGE

The definition of "Qualified Individual" in Section 1.184, Clinical Trial Patient Cost Coverage, in the Description of Covered Services, is deleted and replaced with the following:

> Qualified Individual, as used in this section, means a Member who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to the prevention, early detection, treatment or monitoring of cancer, chronic disease, or other life-threatening illness, and the provider who recommended the Member for the clinical trial has concluded that the Member's participation in such trial is appropriate to prevent, detect early, treat or monitor cancer, chronic disease, or life-threatening illness, or the Member's participation is based on medical and scientific information.

The definition of "Routine Patient Costs" in Section 1.184, Clinical Trial Patient Cost Coverage, in the Description of Covered Services, is deleted and replaced with the following:

> Routine Patient Costs means the costs of all Medically Necessary items and health care services consistent with the Covered Services that are typically provided for a Qualified Individual who is not enrolled in a clinical trial that are incurred as a result of the item, device, or service being provided to the Qualified Individual for purposes of the clinical trial. Routine Patient Costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Section B, Covered Services, is deleted and replaced with the following:

B. Covered Services

1. Benefits for Routine Patient Costs to a Qualified Individual in a clinical trial will be provided if the Qualified Individual's participation in the clinical trial is the result of prevention, early detection, treatment or monitoring of cancer, chronic disease, or other life-threatening illness.

2. Coverage for Routine Patient Costs will be provided only if:

a) The item device or service is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or,

b) The item device or service is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening disease or condition, or chronic disease;

c) The item device or service is being provided in a federally funded or approved clinical trial approved by one of the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and quality, the Centers for Medicare and Medicaid Services, an NIH Cooperative Group, an NIH Center, the FDA in the form of an investigational new drug or device application, the federal Department of Defense, the federal Department of Veterans Affairs, the federal Department of Energy or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant,, or an institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH;

d) The item device or service is being provided under a drug trial that is exempt from the requirement of an investigational new drug application.

e) The facility and personnel providing the item device or service are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

3. Coverage is provided for the Routine Patient Costs incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Qualified Individual's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

SECTION E~~C~~ – MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES ~~SUBSTANCE USE DISORDER PROGRAM~~

1. All references to "Substance Abuse" in the Individual Enrollment Agreement are deleted and replaced with "Substance Use Disorder".

2. Section 8, ~~Inpatient and Outpatient~~ Mental Health and Substance Use Disorder Services, in the Description of Covered Services, is amended to add the following:

8.4 Substance Use Disorder Program. Program benefits will be provided for outpatient treatment of Substance Use Disorder in accordance with the Substance Use Disorder Program if:

A. The Member qualifies for the Substance Use Disorder Program, as determined by CareFirst BlueChoice.

B. The Member receives treatment from a recognized treatment center of excellence, as determined by CareFirst BlueChoice;and

C. Treatment is rendered though an intensive outpatient program (IOP) or an outpatient program at a recognized center of excellence as determined by CareFirst BlueChoice

~~**SECTION C – SUBSTANCE USE DISORDER PROGRAM**~~

~~1. All references to "Substance Abuse" in the Individual Enrollment Agreement are deleted and replaced with "Substance Use Disorder".~~

~~2. Section 9, Inpatient and Outpatient Mental Health and Substance Use Disorder Services, in the Description of Covered Services, is amended to add the following:~~

~~9.4 Substance Use Disorder Program. Program benefits will be provided for outpatient treatment of Substance Use Disorder in accordance with the Substance Use Disorder Program if:~~

~~A. The Member qualifies for the Substance Use Disorder Program, as determined by CareFirst BlueChoice.~~

~~B. The Member receives treatment from a recognized treatment center of excellence, as determined by CareFirst BlueChoice;and~~

~~C. Treatment is rendered though an intensive outpatient program (IOP) or an outpatient program at a recognized center of excellence as determined by CareFirst BlueChoice~~

SECTION ~~D~~F – PRESCRIPTION DRUGS~~SECTION D – PRESCRIPTION DRUGS~~

~~Section 12, Prescription Drugs, in the Description of Covered Services, is deleted and replaced with the following:~~

1. Section 11, Prescription Drugs, in the Description of Covered Services, is deleted and replaced with the following:

~~SECTION 11 PRESCRIPTION DRUGS~~

11.1 Covered Services~~. Except as provided in Section 11.3 below, benefits~~ Benefits will be provided for Prescription Drugs, including but not limited to:

A. Any self-administered contraceptive drug or device, including a contraceptive drug and device on the Preventive Drug List, that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber.- See Section 1.5.B, Contraceptive Methods and Counseling, for additional coverage of contraceptive drugs and devices.

B. Human growth hormones.- Prior authorization is required.

C. Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber, including drugs listed in the Preventive Drug List.

Nicotine Replacement Therapy.- Nicotine Replacement Therapy means a product, including a product on the Preventive Drug List that is used to deliver nicotine to an individual attempting to cease the use of tobacco products, approved by the FDA as an aid for the cessation of the use of tobacco products and obtained under a prescription written by an authorized prescriber.- Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis.

D. Injectable medications that are self-administered and the prescribed syringes and needles.

E. Standard covered items such as insulin, glucagon and anaphylaxis kits.

F. Fluoride products.

G. Diabetic Supplies.

H. Oral chemotherapy drugs.

I. Hormone replacement therapy drugs.

11.2 Dispensing.

A. Non-Maintenance Drugs are limited to up to a thirty (30)-day supply.

B. Maintenance Drugs

1. Coverage for a Maintenance Drug is limited to a thirty (30) day supply for:

a) The first prescription; or,

b) A change in prescription.

2. The day supply for Maintenance Drugs will be based on the following:

a) the prescribed dosage:

b) standard manufacturer's package size, and

c) specified dispensing limits.

C. A Member may obtain up to a twelve (12) month supply of contraceptives at one time.

11.3 Mail Order Program. Except as provided in Section 11.34, all Members have the option of ordering Covered Prescription Drugs via mail order. ~~Members ordering Prescription Drugs through the mail order program will be entitled to a thirty (30) day supply for non-Maintenance Drugs and a ninety (90) day supply for Maintenance Drugs.~~ A Member may obtain up to a twelve (12) month supply of contraceptives at one time.

11.34 Benefits for Specialty Pharmacy Prescription Drugs. Benefits will be provided for Covered Specialty ~~Pharmacy Prescription~~ Drugs only when obtained from a Pharmacy that is part of the Exclusive Specialty Pharmacy Network.

2. Section 13.1. D, General Provisions, Prescription Drug Coverage, is deleted and replaced with the following:

Prescription Drug Coverage.

1. Accessing the Prescription Drug Benefit Card Program.

a) Members may use his/her identification card to purchase Covered Prescription Drugs from Contracting Pharmacy Providers. If the Prescription Drug coverage includes a Deductible, the Member must pay the entire cost of the Covered Prescription Drug(s) until the Deductible is satisfied. Once the Deductible, if applicable, has been satisfied, the Member pays the appropriate Copayment or Coinsurance as stated in the Schedule of Benefits.

b) For Covered Prescription Drugs or diabetic supplies purchased from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst BlueChoice or its designee for reimbursement. In cases of Emergency Services or Urgent Care received outside of the Service Area, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee up to the amount of the total charge, minus any applicable Deductible, Copayment or Coinsurance. In all other cases, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee for the amount up to the Prescription Drug Allowed Benefit, minus

any applicable Deductible, or Copayment or Coinsurance.

c) Except for Specialty Drugs, Members have the option of ordering Covered Prescription Drugs via mail order. The mail order program provides Members with a Pharmacy that has an agreement with CareFirst BlueChoice or its designee, to provide mail service for Covered Prescription Drugs in accordance with the terms of this provision. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance.

2. Additional Terms and Conditions

a) Members or health care providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Covered Prescription Drug in the Prescription Guidelines. A copy of the Prescription Guidelines is available to the Member or provider upon request.

b) Providers may substitute a Generic Drug for a Brand Name Drug. If there is no Generic Drug for the Brand Name Drug the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits for Preferred Brand Name Drugs or Non-Preferred Brand Name Drugs.

c) If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment or Coinsurance when Medically Necessary, as determined by CareFirst BlueChoice.

d) A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment or Coinsurance if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects.

e) When a Generic version of a Prescription Drug becomes available, the Brand Name Drug may be removed from the Formulary or moved to the Non-Preferred level.

f) Members must use 80% of a dispensed non-Maintenance Drug or Maintenance Drug in the manner prescribed before a refill of that prescription can be obtained.

g) armacy Provider by calling the customer service telephone number listed on the identification card.

The Member is responsible for obtaining prior authorization for Covered Prescription Drugs in the Prescription Guidelines when obtained from a non-Contracting Ph

3. How to Obtain Prescription Drugs Not Included in the CareFirst BlueChoice Formulary.

The Member may request an exception for coverage of a Prescription Drug not contained on the CareFirst BlueChoice Formulary.

a) The Member, the Member's authorized representative or the Member's provider may request an exception based upon Medical Necessity by contacting the CareFirst BlueChoice at the telephone number located on the back of the Member's identification card.

b) An exception form should be submitted by the prescribing provider and returned to CareFirst BlueChoice. The prescribing provider may submit a letter of Medical Necessity for dispensing of the non-Covered Prescription Drug.

c) Upon review by the CareFirst BlueChoice, the prescribing provider and the Member or Member's representative will be notified.

i) If the request is approved then the Prescription Drug will be dispensed and the Member will be responsible for the Non-Preferred Brand Name Drug Copayment. If the Prescription Drug exception request is for a non-Formulary Specialty Drug and the exception is granted, then the Member will be responsible for the Non-Preferred Specialty Drug Copayment.

ii) If the exception request is denied, the denial shall be considered an Adverse Decision and may be appealed in accordance with the process outlined in the [Benefit Determination and Appeals Amendment].

In addition, if the exception request is denied, the Member, the Member's representative or the prescribing provider may submit an external exception request to CareFirst BlueChoice requiring that the original exception request and subsequent denial be reviewed by an independent review organization.

4. Timeframe for review and notification of

outcome of exception request:		from the Member's prescribing provider will be completed within twenty-four (24) hours. For purposes of this provision, exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-Formulary Prescription Drug.
a) Urgent requests based on exigent circumstances	b)	Non-urgent requests will be completed within seventy-two (72) hours.
	c)	A request for an external review of the original exception request will be completed no later than twenty-four (24) hours after receipt of the request if the original exception request was urgent and seventy-two (72) hours following receipt of the request if the original exception request was non-urgent.
	d)	CareFirst BlueChoice shall provide coverage for the non-Formulary drug for the duration of the prescription (including refills) if coverage is granted under a standard exception request, or for the duration of the exigency if coverage is granted under an expedited exception request.

~~12.1 Covered Services~~

~~S~~

~~E~~
~~C~~
~~T~~
~~I~~
~~O~~
~~N~~

~~1~~
~~2~~

~~P~~
~~R~~
~~E~~
~~S~~
~~C~~
~~R~~
~~I~~
~~P~~
~~T~~
~~I~~
~~O~~
~~N~~

~~D~~
~~R~~
~~U~~
~~G~~
~~S~~

~~Benefits will be provided for Prescription Drugs, including but not limited to:~~

~~A. Any self-administered contraceptive drug or device, including a contraceptive drug and device on the Preventive Drug List, that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber. See Section 1.5.B, Contraceptive Methods and Counseling, for additional coverage of contraceptive drugs and devices.~~

~~B. Human growth hormones. Prior authorization is required.~~

~~C. Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber, including drugs listed in the Preventive Drug List.~~

~~Nicotine Replacement Therapy. Nicotine Replacement Therapy means a product, including a product on the Preventive Drug List that is used to deliver nicotine to an individual attempting to cease the use of tobacco products, approved by the FDA as an aid for the cessation of the use of tobacco products and obtained under a prescription written by an authorized prescriber. Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis.~~

~~D. Injectable medications that are self-administered and the prescribed syringes and needles.~~

~~E. Standard covered items such as insulin, glucagon and anaphylaxis kits.~~

~~F. Fluoride products.~~

~~G. Diabetic Supplies.~~

~~H. Oral chemotherapy drugs.~~

~~I. Hormone replacement therapy drugs.~~

~~12.2 Dispensing.~~

~~A. Non-Maintenance Drugs are limited to up to a thirty (30)-day supply.~~

~~B. Maintenance Drugs are limited to up to a ninety (90)-day supply.~~

~~C. A Member may obtain up to a twelve (12) month supply of contraceptives at one time.~~

~~12.3 Mail Order Program. Except as provided in Section 12.3, all Members have the option of ordering Covered Prescription Drugs via mail order. Members ordering Covered Prescription Drugs through the mail order program will be entitled to a thirty (30) day supply for non-Maintenance Drugs and a ninety (90) day supply for Maintenance Drugs. A Member may obtain up to a twelve (12) month supply of contraceptives at one time.~~

~~12.4 Benefits for Specialty Pharmacy Prescription Drugs. Benefits will be provided for Covered Specialty Drugs only when obtained from a Pharmacy that is part of the Exclusive Specialty Pharmacy Network.~~

SECTION G - CARE SUPPORT PROGRAMS

The Description of Covered Services is amended to add the following:

Care Support Programs.
A. Definitions

Care Support Programs are health care and wellness programs designed to promote the collaborative

process of assessment, planning, and facilitation, and advocacy for options and services to meet a Qualified Individual's health needs through communication and available resources to promote quality cost-effective outcomes. Care Support Programs include but are not limited to; care coordination, case management, condition specific support, enhanced monitoring, disease management, lifestyle coaching, health promotion and wellness programs.

Designated Provider means a provider or vendor contracted with CareFirst BlueChoice to provide services under CareFirst BlueChoice's Care Support Programs, and who has agreed to participate in Care Support Programs in cooperation with CareFirst BlueChoice for Members with complex chronic disease, high risk acute conditions or lifestyle behavior change.

Qualified Individual, as used in this provision, means a Member with certain conditions or complex health care needs, as determined by CareFirst BlueChoice, requiring care support and coordination of health services. The Member agrees to participate and comply with any and all elements in any given Care Support Program.

B. Covered Services

1. Care Support Programs are available to Qualified Individuals to manage the care of certain complex chronic or high-risk acute diseases when provided by Designated Providers or through CareFirst BlueChoice and are covered at no cost to the Qualified Individual. Covered Services provided under Care Support Programs can include but are not limited to: telemedicine services; case management services; expert consultation services; medication review services; medical equipment and monitoring services; and home health care services.

a) Covered Services received as part of a Care Support Program are subject to applicable contract limits, Deductibles, Copayments, and/or Coinsurance as stated in the Schedule of Benefits.

b) If the Qualified Individual's Evidence of Coverage is compatible with a federally-qualified Health Savings Account and the Qualified Individual has funded his/her HSA account during the Benefit Period, then the Qualified Individual will be responsible for any fees associated with the Member's participation in a Care Support Program until the annual Deductible has been met.

C. Exclusions and Limitations. Coverage will not be provided for the services listed in this amendment when rendered by non-Designated Providers.

~~**SECTION E GENERAL PROVISIONS**~~

~~Section 15.6.General Provisions, Prescription Drug Coverage, in the Description of Covered Services, is deleted and replaced with the following:~~

~~15.6 Prescription Drug Coverage.~~

~~A. Accessing the Prescription Drug Benefit Card Program.~~

~~1. Members may use his/her identification card to purchase Covered Prescription Drugs from Contracting Pharmacy Providers. If the Prescription Drug coverage includes a Deductible, the Member must pay the entire cost of the Covered Prescription Drug(s) until the Deductible is satisfied. Once the Deductible, if applicable, has been satisfied, the Member pays the appropriate Copayment or Coinsurance as stated in the Schedule of Benefits.~~

~~2. For Covered Prescription Drugs or diabetic supplies purchased from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst BlueChoice or its designee for reimbursement. In cases of Emergency Services or Urgent Care received outside of the Service Area, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee up to the amount of the total charge, minus any applicable Deductible, Copayment or Coinsurance. In all other cases, Members~~

will be entitled to reimbursement from CareFirst BlueChoice or its designee for the amount up to the Prescription Drug Allowed Benefit, minus any applicable Deductible, or Copayment or Coinsurance.

3. Except for Specialty Drugs, Members have the option of ordering Covered Prescription Drugs via mail order. The mail order program provides Members with a Pharmacy that has an agreement with CareFirst BlueChoice or its designee, to provide mail service for Covered Prescription Drugs in accordance with the terms of this provision. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance.

B. Additional Terms and Conditions

1. Members or health care providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Covered Prescription Drug in the Prescription Guidelines. A copy of the Prescription Guidelines is available to the Member or provider upon request.

2. Providers may substitute a Generic Drug for a Brand Name Drug. If there is no Generic Drug for the Brand Name Drug the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits for Preferred Brand Name Drugs or Non-Preferred Brand Name Drugs.

3. If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment or Coinsurance when Medically Necessary, as determined by CareFirst BlueChoice.

4. A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment or Coinsurance if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects.

5. When a Generic version of a Prescription Drug becomes available, the Brand Name Drug may be removed from the Formulary or moved to the Non-Preferred level.

6. Members must use 80% of a dispensed non-Maintenance Drug or Maintenance Drug in the manner prescribed before a refill of that prescription can be obtained.

7. The Member is responsible for obtaining prior authorization for Covered Prescription Drugs in the Prescription Guidelines when obtained from a non-Contracting Pharmacy Provider by calling the customer service telephone number listed on the identification card.

C. How to Obtain Prescription Drugs Not Included in the CareFirst BlueChoice Formulary.

The Member may request an exception for coverage of a Prescription Drug not contained on the CareFirst BlueChoice Formulary.

1. The Member, the Member's authorized representative or the Member's provider may request an exception based upon Medical Necessity by contacting the CareFirst BlueChoice at the telephone number located on the back of the Member's identification card.

2. An exception form should be submitted by the prescribing provider and returned to CareFirst BlueChoice. The prescribing provider may submit a letter of

Medical Necessity for dispensing of the non-Covered Prescription Drug.

3. Upon review by the CareFirst BlueChoice, the prescribing provider and the Member or Member's representative will be notified.

a) If the request is approved then the Prescription Drug will be dispensed and the Member will be responsible for the Non-Preferred Brand Name Drug Copayment. If the Prescription Drug exception request is for a non-Formulary Specialty Drug and the exception is granted, then the Member will be responsible for the Non-Preferred Specialty Drug Copayment.

b) If the exception request is denied, the denial shall be considered an Adverse Decision and may be appealed in accordance with the process outlined in the [Benefit Determination and Appeals Amendment].

In addition, if the exception request is denied, the Member, the Member's representative or the prescribing provider may submit an external exception request to CareFirst BlueChoice requiring that the original exception request and subsequent denial be reviewed by an independent review organization.

4. Timeframe for review and notification of outcome of exception request:

a) Urgent requests based on exigent circumstances from the Member's prescribing provider will be completed within twenty-four (24) hours.

For purposes of this provision, exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-Formulary Prescription Drug.

b) Non-urgent requests will be completed within seventy-two (72) hours.

c) A request for an external review of the original exception request will be completed no later than twenty-four (24) hours after receipt of the request if the original exception request was urgent and seventy-two (72) hours following receipt of the request if the original exception request was non-urgent.

d) CareFirst BlueChoice shall provide coverage for the non-Formulary drug for the duration of the prescription (including refills) if coverage is granted under a standard exception request, or for the duration of the exigency if coverage is granted under an expedited exception request.

SECTION F – CLINICAL TRIAL PATIENT COST COVERAGE

The definition of "Qualified Individual" in Section 1.14, Clinical Trial Patient Cost Coverage, in the Description of Covered Services, is deleted and replaced with the following:

Qualified Individual, as used in this section, means a Member who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to the prevention, early detection, treatment or monitoring of cancer, chronic disease, or other life-threatening illness, and the provider who recommended the Member for the clinical trial has concluded that the Member's participation in such trial is appropriate to prevent, detect early, treat or monitor cancer, chronic disease, or life-threatening illness, or the Member's participation is based on medical and scientific information.

The definition of "Routine Patient Costs" in Section 1.14, Clinical Trial Patient Cost Coverage, in the Description of Covered Services, is deleted and replaced with the following:

~~Routine Patient Costs means the costs of all Medically Necessary items and health care services consistent with the Covered Services that are typically provided for a Qualified Individual who is not enrolled in a clinical trial that are incurred as a result of the item, device, or service being provided to the Qualified Individual for purposes of the clinical trial. Routine Patient Costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.~~

~~Section B, Covered Services, is deleted and replaced with the following:~~

~~B. Covered Services~~

~~1. Benefits for Routine Patient Costs to a Qualified Individual in a clinical trial will be provided if the Qualified Individual's participation in the clinical trial is the result of prevention, early detection, treatment or monitoring of cancer, chronic disease, or other life-threatening illness.~~

~~2.~~1. Coverage for Routine Patient Costs will be provided only if:

~~a)~~ The item device or service is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or,

~~b)~~a) The item device or service is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening disease or condition, or chronic disease;

~~c)~~a) The item device or service is being provided in a federally funded or approved clinical trial approved by one of the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and quality, the Centers for Medicare and Medicaid Services, an NIH Cooperative Group, an NIH Center, the FDA in the form of an investigational new drug or device application, the federal Department of Defense, the federal Department of Veterans Affairs, the federal Department of Energy or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant,, or an institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH;

~~d)~~a) The item device or service is being provided under a drug trial that is exempt from the requirement of an investigational new drug application.

~~e)~~a) The facility and personnel providing the item device or service are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

~~3.~~1. Coverage is provided for the Routine Patient Costs incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Qualified Individual's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

SECTION H – EXCLUSIONS AND LIMITATIONS

Section 1~~5~~6.1GG~~KK~~ Exclusions and Limitations, is deleted and replaced with the following exclusion:

1~~5~~6.GG~~KK~~	Services required solely for administrative purposes, for example, employment, insurance, foreign travel, school, camp admissions or participation in sports activities. [However, immunizations for foreign travel, when provided at the university health center, will

be covered.]

Section 156.1, Exclusions and Limitations, is amended to add the following exclusion:

~~16.1 OO Except as otherwise provided, Prescription Drugs not contained in the CareFirst BlueChoice Formulary.~~

[15.11 Injury sustained while;

- Participating in any intercollegiate or professional sport, contest or competition.
- Traveling to or from such sport, contest or competition as a participant.
- Participating in any practice or conditioning program for such sport, contest or competition.]

~~**SECTION I – DIABETES TREATMENT**~~

~~1. Section 1.7, Diabetes Treatment, in the In-Network Description of Covered Services, is deleted and replaced with the following:~~

~~1.7 Diabetes Treatment.~~

~~A. Coverage will be provided for Medically Necessary diabetes treatment and outpatient self-management training and educational services, including medical nutritional counseling at a CareFirst BlueChoice-approved facility. Diabetic equipment and Diabetic Supplies are covered under the Medical Devices and Supplies Section within the Description of Covered Services. Diabetic Supplies are also covered under the Prescription Drug Section within the Description of Covered Services.~~

~~B. The services must be Medically Necessary as determined by CareFirst BlueChoice for the treatment of diabetes (Types I and II), elevated or impaired blood glucose levels induced by pregnancy.~~

~~C. In-person, outpatient self-management training and educational services, including medical nutritional therapy, shall be provided through an in- person program provided by an appropriately licensed, registered, or certified CareFirst BlueChoice approved facility or health care provider whose scope of practice includes diabetes education or management.~~

~~2. Section 11.1.E in the In-Network Description of Covered Services is deleted and replaced with the following:~~

~~E. Diabetes Equipment and Supplies. Coverage will be provided for all Medically Necessary and medically appropriate equipment and diabetic supplies necessary for the treatment of diabetes (Types I and II), elevated or impaired blood glucose levels induced by pregnancy.~~

~~1. Diabetes equipment includes glucose monitoring equipment under the durable medical equipment coverage for insulin-using beneficiaries. Coverage will be provided for insulin pumps.~~

~~2. Diabetes supplies include coverage for insulin syringes and needles and testing strips for glucose monitoring equipment for insulin-using beneficiaries. Diabetic Supplies are also covered under the Prescription Drug Section~~

~~3. Insulin using beneficiary means a Member who uses insulin as part of a treatment plan prescribed by his/her medical care provider.~~

[SECTION I – ACUPUNCTURE SERVICES

Section 1.11, Outpatient Therapeutic Treatment Services of the Description of Covered Services is amended to add the following:

H. Acupuncture Services. Benefits will be provided for Medically Necessary acupuncture services when provided by a provider licensed to perform such services.]

[SECTION J~~I~~ – MASSAGE THERAPY

Benefits will be provided for massage therapy when provided in a Student Health Center. Benefits will be provided regardless of Medical Necessity. Benefits are limited to two (2) visits per Benefit Period.]

~~**SECTION B – HABILITATIVE SERVICES**~~

~~Section 1.10, Habilitative Services, in the In-Network Description of Covered Services, is deleted and replaced with the following:~~

~~1.10 Habilitative Services.~~

~~A. Members until the end of the month in which the Member turns nineteen (19) years old.~~

~~1. Coverage for Habilitative services includes health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include services for cleft lip and cleft palate, orthodontics, oral surgery, otologic, audiological, and speech therapy, physical therapy, occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.~~

~~2. Benefits are not available for Habilitative services delivered through early intervention and school services.~~

~~3. Benefits are not counted toward any visit maximum for Outpatient Rehabilitation Therapy services.~~

~~B. For Members age nineteen (19) and over.~~

~~1. Benefits are available to Members on the first day of the month after the Member turns age nineteen (19).~~

~~2. Coverage for Habilitative services includes health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.~~

~~3. Benefits are available to the same extent as benefits provided for Outpatient Rehabilitative Services.~~

~~C. Prior authorization is required.~~

SECTION C – PRESCRIPTION DRUGS

1. Section 12, Prescription Drugs, Provision 12.2, Dispensing, in the In-Network Description of Covered Services, is deleted and replaced with the following:

12.2 Dispensing.

A. Non-Maintenance Drugs are limited to up to a thirty (30)-day supply. For a partial supply of Prescription Drug, the Copayment or Coinsurance will be prorated on a daily basis not to exceed the amount due for a 30-day supply as stated in the Schedule of Benefits.

B. Maintenance Drugs are limited to up to a ninety (90)-day supply. For a partial supply of Prescription Drug, the Copayment or Coinsurance will be prorated on a daily basis not to exceed the amount due for a 90-day supply as stated in the Schedule of Benefits.

C. Contraceptive drugs and devices:

1. Coverage will be provided for a single dispensing of a six (6) month supply of prescription contraceptives.

2. Provision C.1 does not apply if:

a) The six (6) month supply would extend beyond the end of the Benefit Period. In which case the Member would be able to receive up to a ninety (90)-day supply; or,

b) The coverage is for the first two (2) month supply dispensed to the Member under:

i) The initial prescription for contraceptives; or,

ii) Any subsequent prescription for a contraceptive that is different from the last contraceptive dispensed to the Member.

D. When a partial supply of Prescription Drug is dispensed by Contracting Pharmacy, a prorated daily copayment or coinsurance for the partial supply of the Prescription Drug shall be applied if:

1. The prescriber or the Pharmacist determines dispensing a partial supply of a Prescription Drug to be in the best interest of the member;

2. The Prescription Drug is anticipated to be required for more than 3 months;

3. The member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the member's Prescription Drugs;

4. The Prescription Drug is not a Schedule II controlled dangerous substance; and

5. The supply and dispensing of the Prescription Drug meets all prior authorization and utilization management requirements specific to the Prescription Drug at the time of the synchronized dispensing.

This provision applies only to a partial supply of Prescription Drugs dispensed by a Contracting Pharmacy.

This amendment is issued to be attached to the Individual Enrollment Agreement. This amendment does not change the terms and conditions of the Individual Enrollment Agreement, unless specifically stated herein.

CareFirst BlueChoice, Inc.

[Signature]

_____

[Name]
[Title]

CareFirst BlueChoice, Inc.
[840 First Street, NE]
[Washington, DC
20065]
[202-479-8000]

An independent licensee of the Blue Cross and Blue Shield Association

IN-NETWORK STUDENT HEALTH PLAN
INDIVIDUAL ENROLLMENT AGREEMENT

This is the In-Network Agreement for the jointly offered Point-of-Service product with In-Network HMO benefits administered by CareFirst BlueChoice, Inc. and Out-of-Network indemnity benefits administered by Group Hospitalization and Medical Services, Inc., doing business as, CareFirst BlueCross BlueShield (CareFirst). Each time that services are sought, the Member may choose to receive In-Network HMO benefits or Out-of-Network indemnity benefits.

This In-Network Agreement, including any duly authorized attachments, notices, amendments, and riders, is a part of the Academic Institution Contract issued to the Subscriber and contains the principal provisions affecting the Member(s) Academic Institution (Institution of Higher Education) through which Subscribers are enrolled under the In-Network Agreement and other provisions that explain the duties of CareFirst BlueChoice and those of the Subscriber or Application Filer.

The Academic Institution accepts and agrees to the In-Network Agreement and the Out-of-Network Academic Institution Contract by making payment of the initial Premium to CareFirst BlueChoice. CareFirst BlueChoice agrees to the In-Network Academic Institution Contract when it is issued to the Subscriber.

CareFirst BlueChoice may, under certain circumstances, discontinue coverage of a Member or terminate this In-Network Agreement. See Section 4 of the In-Network Agreement for additional information.

NOTE: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition CareFirst BlueChoice may deny insurance benefits if false information materially related to a claim was provided by the applicant.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE: In the event the Subscriber needs to contact someone about this insurance for any reason, the Subscriber should contact their agent. If no agent was involved in the sale of this insurance, or if the Subscriber has additional questions, the Subscriber may contact the insurance company issuing this insurance at the following address: 840 First Street, NE, Washington, DC 20065, and telephone number: 202-479-8000. Written correspondence is preferable so that a record of the Subscriber's inquiry is maintained. When contacting the agent, company or the Bureau of Insurance, the Subscriber should have their policy number available.

CareFirst BlueChoice recommends that the Subscriber familiarizes himself or herself with the CareFirst BlueChoice complaint and appeal ~~procedure, and~~procedure and make use of it before taking any other action.

[Subscriber Name:]

[Subscriber ID Number:]

[Product Name:]

[Effective Date:]

~~Subscriber Name: _____~~

~~Subscriber ID Number: _____~~

~~Product Name: _____~~

~~Effective Date: _____~~

Term: This Agreement will have an initial term from the Agreement Effective Date stated above until the last day of the Academic Institution Contract year. This Agreement is a conditionally renewable plan.

CareFirst BlueChoice, Inc.

[Signature]

_____

[Name]
[Title]

SECTION 1
DEFINITIONS

The underlined terms when capitalized are defined as follows:

Academic Institution means the organization to which CareFirst BlueChoice has issued an Academic Institution Contract pursuant to which Eligible Students and their Dependents, to the extent such dependents are covered under this Agreement, are enrolled for covered health benefits. as set forth herein.

Academic Institution Contract means the contract, including all duly authorized attachments, notices, amendments and riders, between CareFirst and the Academic Institution.

Adoption means the earlier of a judicial decree of adoption or, the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.

Adult means an individual eighteen (18) years old or older.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152).

Agreement means this policy, which includes all attachments, amendments and riders, if any, between the Academic Institution and CareFirst BlueChoice (also referred to as the Academic Institution Contract).

Allowed Benefit means:

A. For a Contracting Provider, the Allowed Benefit for a Covered Service is the lesser of:

1. The provider's actual charge which, in some cases, will be a rate set by a regulatory agency; or

2. The benefit amount, according to the CareFirst BlueChoice rate schedule, for the Covered Service that applies on the date that the service is rendered.

B. For Emergency Services provided by a Non-Contracting Provider, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge, or the amount that would be paid to a Contracting Provider for the Covered Service; in no event shall the Allowed Benefit be less than the amount allowed by Medicare. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the practitioner's actual charge. The provider may bill the Member directly for such amounts.

. The Member is responsible for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits.

Pediatric Dental Allowed Benefit means:

For Preferred Dentists, the Pediatric Dental Allowed Benefit payable to a Preferred Dentist for a Covered Dental Service will be the amount agreed upon between the Dental Plan and the Preferred Dentist. The Pediatric Dental Allowed Benefit is accepted by the Preferred Dentist as payment in full, except for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits.

Prescription Drug Allowed Benefit means the lesser of:

A. The Pharmacy's actual charge; or

B. The benefit amount, according to the CareFirst BlueChoice fee schedule, for covered Prescription Drugs that applies on the date the service is rendered.

If the Member purchases a covered Prescription Drug or diabetic supply from a Contracting Pharmacy Provider, the benefit payment is made directly to the Contracting Pharmacy Provider and is accepted as payment in full, except for any applicable Deductible, Copayment, or Coinsurance. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance and the Contracting Pharmacy Provider may bill the Member directly for such amounts.

If the Member purchases a covered Prescription Drug from a Non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst or its designee in the amount of the Allowed Benefit, minus any applicable Deductible, Copayment, or Coinsurance. Members may be responsible for balances above the Allowed Benefit.

Pediatric Vision Allowed Benefit means:

A. For a Contracting Vision Provider, the Pediatric Vision Allowed Benefit for a covered service is the lesser of:

1. The actual charge; or

2. The benefit amount, according to the Vision Care Designee's rate schedule for the covered service or supply that applies on the date the service isrendered.

The benefit payment is made directly to a Contracting Vision Provider. When a Member receives Covered Vision Services from a Contracting Vision Provider, the benefit payment is accepted as payment in full, except for any applicable Copayment. When a Member receives frames and spectacle lenses or contact lenses from a Contracting Vision Provider, the benefit payment is as stated in the Schedule of Benefits below. The Contracting Vision Provider may collect any applicable Copayment or amounts in excess of the Vision Care Designee's payment when other frames and nonstandard spectacle lenses or other contact lenses are purchased by the Member.

B. For a Non-Contracting Vision Provider, the Allowed Benefit for Vision Care will be determined in the same manner as the Allowed Benefit to a Contracting Vision Provider.

Benefits may be paid to the Subscriber or to the Non-Contracting Vision Provider at the discretion of the Vision Care Designee. The Member is responsible for the cost difference between the Vision Care Designee's payment and the Non-Contracting Vision Provider's actual charge. The Non-Contracting Vision Provider may bill the Member directly. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Contracting Vision Provider.

Vision Allowed Benefit means:

A. For a Contracting Vision Provider, the Vision Allowed Benefit for a covered service is the lesser of:

1. The actual charge; or

2. The benefit amount, according to the Vision Care Designee's rate schedule for the covered service or supply that applies on the date the service isrendered.

The benefit payment is made directly to a Contracting Vision Provider. When a Member receives Covered Vision Services from a Contracting Vision Provider, the benefit payment is accepted as payment in full, except for any applicable Copayment. When a Member receives frames and spectacle lenses or contact lenses from a Contracting Vision Provider, the benefit payment is as stated in the Schedule of Benefits below. The

Contracting Vision Provider may collect any applicable Copayment or amounts in excess of the Vision Care Designee's payment when other frames and non-standard spectacle lenses or other contact lenses are purchased by the Member.

B. For a Non-Contracting Vision Provider, the Allowed Benefit for Vision Care will be determined in the same manner as the Allowed Benefit to a Contracting Vision Provider.

Benefits may be paid to the Subscriber or to the Non-Contracting Vision Provider at the discretion of the Vision Care Designee. The Member is responsible for the cost difference between the Vision Care Designee's payment and the Non- Contracting Vision Provider's actual charge. The Non-Contracting Vision Provider may bill the Member directly. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Contracting Vision Provider.

Annual Open Enrollment Period means the periods during each Contract Year during which an eligible individual may enroll or change coverage under this Agreement.

Benefit Period means the Contract Year during which coverage is provided for Covered Services, Covered Dental Services and Covered Vision Services.

Bereavement Counseling means counseling provided to the Immediate Family or Family Caregiver of the Member after the Member's death to help the Immediate Family or Family Caregiver cope with the death of the Member.

Body Mass Index (BMI) means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand Name Drug means a Prescription Drug that has been given a name by a manufacturer or distributor to distinguish it as produced or sold by a specific manufacturer or distributor and that may be used and protected by a trademark.

Cardiac Rehabilitation means inpatient or outpatient services designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse atherosclerotic process and enhance the psychosocial and vocational status of eligible Members.

CareFirst BlueCross BlueShield (CareFirst) means the business name of Group Hospitalization and Medical Services, Inc. (GHMSI)

Caregiver means a person who is not a health care provider, who lives with or is the primary Caregiver of the terminally-ill Member in the home. The Caregiver can be a relative by blood, marriage, or Adoption (see Family Caregiver definition), or a friend of the Member, but cannot be a person who normally charges for providing services. However, at CareFirst's discretion, a Caregiver may be an employee of a hospice care hospital/agency.

Chemotherapy means the chemical or biological antineoplastic agents administered as part of a doctor's visit, home care visit, or at an outpatient facility for treatment of an illness.

Coinsurance means the percentage of the Allowed Benefit allocated between CareFirst and the Member, whereby CareFirst and the Member share in the payment for Covered Services, Covered Dental Services, or Covered Vision Services.

Contract Year means 365 days from the effective date of the In-Network Agreement each year.

Contracting Pharmacy Provider means the separate independent Pharmacist or Pharmacy, including a pharmacy in the Exclusive Specialty Pharmacy Network that has contracted with CareFirst BlueChoice or its designee to provide Prescription Drugs in accordance with the terms of this Agreement.

Contracting Provider means any physician, health care professional, health care facility or Contracting Pharmacy Provider that has contracted with CareFirst BlueChoice, Inc. to render Covered Services to Members. A Preferred Dentist who provides Covered Dental Services or a Contracting Vision Provider who provides Covered Vision Services is not a Contracting Provider for the purposes of this definition.

Contracting Vision Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Covered Vision Services are rendered when acting within the scope of such license and that has contracted with the Vision Care Designee to provide Covered Vision Services.

Convenience Item personal hygiene and convenience items, including but not limited to: air conditioners, humidifiers, physical fitness equipment, elevators, hoyer/stair lifts, ramps, shower/bath benches, and items available without a prescription~~means any item that increases physical comfort or convenience without serving a Medically Necessary purpose (e.g., elevators, hoyer/stair lifts, ramps, shower/bath benches, and items available without a prescription).~~

Copayment (Copay) means the fixed dollar amount that a Member must pay for certain Covered Services, Covered Dental Services or Covered Vision Services.

Cosmetic means a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst.

Covered Dental Services means Medically Necessary services or supplies listed in Section 2 of the Description of Covered Services.

Covered Prescription Drug means a Prescription Drug included in the CareFirst BlueChoice Formulary.

Covered Specialty Drug means a Specialty Drug included in the CareFirst BlueChoice Formulary.

Covered Service means Medically Necessary services or supplies provided in accordance with the terms of this Agreement other than Covered Dental Services or Covered Vision Services.

Covered Specialty Drug means a Specialty Drug included in the CareFirst BlueChoice Formulary.

Covered Vision Services means Medically Necessary services or supplies listed in Sections 3 and 4 of the Description of Covered Services.

Custodial Care means care provided primarily to meet the personal needs of the patient. Custodial Care does not require skilled medical or paramedical personnel. Such care includes help in walking, bathing, or dressing. Custodial Care also includes preparing food or special diets, feeding, administering medicine, or any other care that does not require continuing services of medically trained personnel.

Deductible means the dollar amount of the Allowed Benefits payable during a Benefit Period for Covered Services or Covered Dental Services that must first be incurred by the Member before CareFirst will make payments for Covered Services or Covered Dental Services.

Dental Director is a Dentist appointed by the Medical Director of CareFirst BlueChoice to perform administrative duties with regard to the dental services listed in this Agreement.

Dental Plan means the dental program under which the Covered Dental Services are made available to Members. The Dental Plan is offered in conjunction Group Hospitalization and Medical Services, Inc. (GHMSI), doing business as CareFirst BlueCross BlueShield (CareFirst). CareFirst contracts with Preferred Dentists and provides claims processing and administrative services under the Dental Plan.

Dentist means an individual who is licensed to practice dentistry as defined by the respective jurisdiction where the practitioner provides care.

Dependent means a Member who is covered under this Agreement as the eligible Spouse, eligible Dependent Child, eligible Domestic Partner of a Subscriber, or eligible Dependent Child of a Domestic Partner as defined in this Agreement. If the Academic Institution does not elect coverage for Dependents, these individuals are not eligible for coverage under this Agreement.

Dependent Child or Dependent Children means an eligible individual as defined in Section 2.4.

Domestic Partner means an eligible unmarried same or opposite sex adult who resides with the Member and has registered in a state or local domestic partner registry with a Member

Domestic Partnership means a relationship between the Subscriber and Domestic Partner that meets the criteria stated in Section 2.3.

Effective Date means the date on which the Member's coverage becomes effective. Covered Services, Covered Dental Services, and Covered Vision Services rendered on or after the Member's Effective Date are eligible for coverage.

Eligible Student means an individual eligible under the guidelines defined by the Academic Institution sponsoring this Agreement who is an admitted or continuing candidate in a recognized degree or certificate program sponsored by the Academic Institution. For purposes of this definition, "Candidacy in a recognized degree or certificate program" is defined as:

A. Candidacy during academic semester

   A student is an admitted or continuing candidate in a recognized degree or certificate program if the student is actively pursuing the course of study required by the degree or certificate program. The student must satisfy the requirements of his course of study which may involve maintaining minimum credit hours, research units or involvement in approved intern or work/study programs. Academic semester may include summer. Additionally, eligibility may be defined as continuing education courses, affiliated research assistantships, or post-doctoral research after graduation from a recognized degree program (e.g., a student fellowship).

B. Candidacy between academic semesters

   A student who maintains candidacy in a recognized degree or certificate program during an academic semester or session keeps such candidacy until the close of the next semester's or session's registration period.

A student's eligibility may continue in this manner until the student's candidacy is withdrawn by the student or terminated by the institution.

Emergency Medical Condition means the sudden and unexpected onset of a medical condition of sufficient severity, including severe pain, when the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

A. Serious jeopardy to the mental or physical health of the individual;

B. Danger of serious impairment of the individual's bodily functions;

C. Serious dysfunction of any of the individual's bodily organs or parts; or

D. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as CareFirst determines.

Emergency Services means, with respect to an Emergency Medical Condition:

A. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

B. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to stabilize the Member. The term to "stabilize" with respect to an Emergency Medical Condition, means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta; or as otherwise defined under 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Enhanced Monitoring Program (EMP) means the CareFirst BlueChoice program for Members with a chronic condition or disease for which medical equipment and monitoring services are provided to help the Member manage the chronic condition or disease.

Experimental/Investigational means a service or supply in the developmental stage and in the process of human or animal testing excluding patient costs for clinical trials as stated in the Description of Covered Services. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

A. The Technology* must have final approval from the appropriate government regulatory bodies;

B. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;

C. The Technology must improve the net health outcome;

D. The Technology must be as beneficial as any established alternatives; and

E. The improvement must be attainable outside the Investigational settings.

* "Technology" includes drugs, devices, processes, systems, or techniques.

A drug is not considered Experimental or Investigational as long as: it is used to treat a covered indication; it has been approved by the FDA for at least one indication; and, it is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer review medical literature.

Exclusive Specialty Pharmacy Network means a pharmacy network that is limited to certain specialty Pharmacies that have been designated as "Exclusive" by CareFirst BlueChoice. . Members may contact CareFirst BlueChoice for a list of Pharmacies in the Exclusive Specialty Pharmacy Network.

Expert Consultation Program (ECP) means the CareFirst BlueChoice Program for Members with a

complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

FDA means the United States Food and Drug Administration.

Family Caregiver means a relative by blood, marriage, or Adoption who lives with or is the primary Caregiver of the terminally ill Member.

Family Counseling means counseling given to the Immediate Family or Family Caregiver of the terminally ill Member for the purpose of learning to care for the Member and to adjust to the impending death of the Member.

Formulary means the list of Prescription Drugs issued by CareFirst and used by health care providers when writing, and Pharmacists, when filling, prescriptions for which coverage will be provided under this Agreement. CareFirst may change this list periodically without notice to Members. A copy of the Formulary is available to the Member upon request.~~means the means the list of Prescription Drugs issued by CareFirst BlueChoice and used by health care providers when writing, and Pharmacists, when filling, prescriptions for which coverage will be provided under this Agreement. CareFirst BlueChoice may change this list periodically without notice to Members. A copy of the Formulary is available to the Member upon request.~~

Generic Drug means any Prescription Drug approved by the FDA that has the same bio-equivalency as a specific Brand Name Drug.

Home Health Care or Home Health Care Services means the continued care and treatment of a Member in the home by a licensed Home Health Agency if:

A. The institutionalization of the Member in a hospital, related institution, or Skilled Nursing Facility would otherwise have been required if Home Health Care Services were not provided; and

B. The Plan of Treatment covering the Home Health Care Service is established and approved in writing by the health care ~~provider, and~~provider and determined to be Medically Necessary by CareFirstBlueChoice.

Immediate Family means the Spouse, parents, siblings, grandparents, and children of the terminally ill Member.

In-Network means Point-of-Service benefits provided to the Member under this In-Network Agreement.

In-Network Agreement means this Point-of-Service In-Network agreement between CareFirst BlueChoice and the Academic Institution, and it includes thise In-Network Individual Enrollment Agreement, the [Benefit Determination and Appeal and Grievance Procedures], Description of Covered Services, Schedule of Benefits, and any duly authorized notices, amendments and riders.

Infusion Services means treatment provided by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion Services also includes enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. Infusion Services includes all medications administered intravenously and/or parenterally.

Limiting Age means the maximum age to which a Dependent Child may be covered. The Limiting Age is the age of twenty-six (26).

Low Vision means a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in Low Vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Members with Low Vision.

Maintenance Drug means a Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.

Mastectomy means the surgical removal of all or part of the breast.

Medication Assisted Treatment (MAT) means Prescription Drugs used to treat Substance Use Disorders (Alcohol Misuse and opioid misuse).

Medical Child Support Order (MCSO) means an order issued in the format prescribed by federal law and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An order means a judgment, decree, or a ruling (including approval of a settlement agreement) that:

A. Is issued by a court or administrative child support enforcement agency of any state or the District of Columbia; and

B. Creates or recognizes the right of a child to receive benefits under a parent's health insurance coverage; or establishes a parent's obligation to pay child support and provide health insurance coverage for a child.

Medical Director means a ~~board certified~~board-certified physician who is appointed by CareFirst. The duties of the Medical Director may be delegated to qualified persons.

Medically Necessary or Medical Necessity means health care services or supplies that a health care provider, exercising clinical judgment, renders to or recommends for a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease, or its symptoms. These health care services or supplies are:

A. In accordance with generally accepted standards of medical practice;

B. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;

C. Not primarily for the convenience of a patient or health care provider; and

D. Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of the patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of health care providers practicing in relevant clinical areas, and any other relevant factors.

The fact that a health care provider may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by the Agreement.

Medical Nutrition Therapy provided by a licensed dietitian-nutritionist involves the assessment of the Member's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. The licensed dietitian-nutritionist, working in a coordinated, multidisciplinary team effort with the Primary Care Physician, takes into account a Member's condition, food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

Member means an individual who meets all applicable eligibility requirements, who is enrolled either as a Subscriber or Dependent, if the Academic Institution elects coverage for Dependents, and for whom Premiums have been collected by the Academic Institution and remitted to CareFirst BlueChoice .

Minimum Essential Coverage has the meaning given in the Affordable Care Act, 26 U.S.C. §5000A(f).

Morbid Obesity means a:

A. Body Mass Index that is greater than forty (40) kilograms per meter squared; or

B. Body Mass Index equal to or greater than thirty-five (35) kilograms per meter squared with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

Non-Contracting Physician means a licensed doctor who is not contracted with CareFirst BlueChoice to provide Covered Services to Members.

Non-Contracting Provider means any health care provider that has not contracted with CareFirst BlueChoice to provide Covered Services to Members. Neither Participating Dentists or Non-Participating Dentists who provide Covered Dental Services nor Non-Contracting Vision Providers who provide Covered Vision Services are Non-Contracting Providers for the purposes of this definition.

Non-Contracting Vision Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Covered Vision Services are rendered when acting within the scope of such license; and, who does not have an agreement with the Vision Care Designee for the rendering of Covered Vision Services. A Non-Contracting Vision Provider may or may not have contracted with CareFirst BlueChoice. The Member should contact the Vision Care Designee for the current list of Contracting Vision Providers.

Non-Preferred Dentist means any Dentist who is not a Preferred Dentist, including a Participating Dentist or a Non-Participating Dentist.

Non-Preferred Provider means a health care provider that does not contract with CareFirst to provide Covered Services. Neither Participating Dentists or Non-Participating Dentists who provide Covered Dental Services nor Non-Contracting Vision Providers who provide Covered Vision Services are Non-Preferred Providers for the purposes of this definition.

Non-Preferred Brand Name Drug means a Brand Name Drug included in the Formulary as a Covered Prescription Drug but not included on the Preferred Drug List.

Non-Preferred Specialty Drug means a Specialty Drug included in the Formulary as a Covered Prescription Drug but not included on the Preferred Drug List.

Out-of-Network means Point-of-Service benefits provided to the Member under the Out-of-Network Agreement issued to the Subscriber by CareFirst BlueCross BlueShield.

Out-of-Network Academic Institution Contract means the complete Point-of-Service Out-of-Network agreement between CareFirst BlueCross BlueShield and the Academic Institution and it includes the Academic Institution Contract Application, the Out-of-Network Academic Institution Contract, Out-of-Network Individual Enrollment Agreement, [Benefit Determination and Appeal and Grievance Procedures], Out-of-Network Description of Covered Services, Out-of-Network Schedule of Benefits, and any duly authorized notices, amendments and riders.

Out-of-Pocket Maximum means the maximum amount the Member will have to pay for his/her share of benefits in any Benefit Period. The Out-of-Pocket Maximum does not include Premiums, amounts incurred for failure to comply with utilization management requirements, the cost of services that are not Covered Services, or any balance bill. Once the Member meets the Out-of-Pocket Maximum, the Member will no longer be required to pay Copayments, Coinsurance, or Deductible for the remainder of the Benefit Period.

Outpatient Rehabilitative Services means occupational therapy, speech therapy and physical therapy provided to Members not admitted to a hospital or related institution.

Over-the-Counter means any item or supply as determined by CareFirst available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception items for men, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and related over-the-counter medications, solutions, items or supplies.

Participating Dentist means any Dentist who, at the time of rendering a Covered Dental Service to the Member, has a written agreement with CareFirst or CareFirst's designee for the rendering of such service. Participating Dentist means any Dentist who, at the time of rendering a Covered Dental Service to a Member, has a written agreement with CareFirst BlueChoice, or CareFirst BlueChoice's designee, for the rendering of such service.

Pharmacist means an individual licensed to practice pharmacy regardless of the location where the activities of practice are performed.

Pharmacy means an establishment in which prescription or nonprescription drugs or devices are compounded, dispensed, or distributed.

Plan of Treatment means the plan written and given to CareFirst BlueChoice by the attending health care provider on CareFirst BlueChoice forms which shows the Member's diagnoses and needed treatment.

Preferred Brand Name Drug means a Brand Name Drug that is included on CareFirst BlueChoice's Preferred Drug List.

Preferred Dentist means one of a network of Participating Dentists who, at the time of rendering a Covered Service to the Member, has a written agreement with the Dental Plan for the rendering of such service.

Preferred Drug List means the list of Preferred Drugs issued by CareFirst BlueChoice and used by health care providers when writing, and Pharmacists, when filling, prescriptions. All Generic Drugs are included in the Preferred Drug List. Not all Brand Name Drugs listed in the Formulary are included in the Preferred Drug List. CareFirst BlueChoice may change this list periodically without notice to Members. A copy of the Preferred Drug List is available to the Member upon request.~~means the list of Preferred Drugs issued by CareFirst BlueChoice and used by health care providers when writing, and Pharmacists, when filling, prescriptions. All Generic Drugs are included in the Preferred Drug List. Not all Brand Name Drugs listed in the Formulary are included in the Preferred Drug List. CareFirst BlueChoice may change this list periodically without notice to Members. A copy of the Preferred Drug List is available to the Member upon request.~~

Preferred Specialty Drug means a Specialty Drug included in the Preferred Drug List.

Premium. means the dollar amount the Academic Institution on behalf of the Subscriber remits to CareFirst for health care benefits provided under both the In-Network Agreement and the Out-of-Network Agreement.

Premium Due Date is the date determined by CareFirst.

Prescription Drug means:

A. A drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;"

B. Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst BlueChoice ;

C. A covered Over-the-Counter medication or supply; or

D. Any Diabetic Supply.

E. Prescription Drugs do not include:

1. Compounded bulk powders that contain ingredients that:

a) Do not have FDA approval for the route of administration being compounded, OR

b) Have no clinical evidence demonstrating safety and efficacy, OR

c) Do not require a prescription to be dispensed.

2. Compounded drugs that are available as a similar commercially available Prescription Drug unless:

a) There is no commercially available bio-equivalent Prescription Drug; OR

b) The commercially available bio-equivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

Prescription Guidelines means the limited list of Prescription Drugs issued by CareFirst BlueChoice for which providers, when writing, and Pharmacists, when filling prescriptions, must obtain prior authorization from CareFirst BlueChoice, the quantity limits that CareFirst BlueChoice has placed on certain drugs. A copy of the Prescription Guidelines is available to the Member upon request.

Preventive Drug means. Prescription Drug or Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is included on the CareFirst BlueChoice Preventive Drug List.

Preventive Drug List means the list issued by CareFirst BlueChoice of Prescription Drugs or Over-theCounter medications or supplies dispensed under a written prescription by a health care provider that have been identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration. A copy of the Preventive Drug List is available to the Member upon request.

Primary Care Physician (PCP) means a Contracting Provider selected by a Member to provide and manage the Member's health care. PCP means health care practitioners in the following disciplines:

A. General internal medicine;

B. Family practice medicine;

C. General pediatric medicine; or

D. Geriatric medicine.

Services rendered by Specialists in the disciplines above will be treated as PCP visits for Member payment purposes.

Professional Nutritional Counseling means individualized advice and guidance given to a Member at nutritional risk due to nutritional history, current dietary intake, medication use, or chronic illness or condition, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a licensed dietitian-nutritionist, physician, physician assistant, or nurse practitioner.

Qualified Home Health Agency means a licensed program approved for participation as a home health agency under Medicare, or certified as a home health agency by the Joint Commission on Accreditation of Healthcare Organizations, its successor, or the applicable state regulatory agency.

Qualified Hospice Care Program means a coordinated, interdisciplinary program provided by a hospital, Qualified Home Health Agency, or other health care facility licensed or certified by the state in which it operates as a hospice program and is designed to meet the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and

bereavement period. Benefits are available to:

A. Individuals who have no reasonable prospect of cure as estimated by a physician; and

B. The immediate families or Family Caregivers of those individuals.

Qualified Medical Support Order (QMSO) means a Medical Child Support Order, issued under state law or the laws of the District of Columbia, that is issued to an employer sponsored health plan that complies with section 609(A) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Rescind or Rescission means a termination, cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual's enrollment is a Rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a Rescission for this purpose. Coverage is not Rescinded and a cancellation or discontinuance of coverage is not a Rescission if:

A. The termination, cancellation or discontinuance of coverage has only a prospective effect; or

B. The termination, cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due.

Respite Care means temporary care provided to the terminally ill Member to relieve the Caregiver/Family Caregiver from the daily care of the Member.

Respiratory Therapy means the use of dry or moist gases in the lungs, non pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; bronchopulmonary drainage and breathing exercises.

Service Area means the clearly defined geographic area in which CareFirst BlueChoice has arranged for the provision of health care services to be generally available and readily accessible to Members, except for emergency services. CareFirst may amend the defined Service Area at any time by notifying the Subscriber in writing.

The Service Area is as follows: the District of Columbia; the state of Maryland; in the Commonwealth of Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the areas of Fairfax and Prince Williams Counties in Virginia lying east of Route 123.

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that is accredited or approved under Medicare or The Joint Commission and provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care, or rehabilitation services. Inpatient skilled nursing is for patients who are medically fragile with limited endurance and require a licensed health care professional to provide skilled services in order to ensure the safety of the patient and to achieve the medically desired result. Inpatient skilled nursing services must be provided on a 24 hour basis, 7 days a week.

Sound Natural Teeth means teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers, and crowns) that are in good condition; absent decay, fracture, bone loss, periodontal disease, root canal pathology or root canal therapy and excludes any tooth replaced by artificial means (implants, fixed or removable bridges, dentures).

Special Enrollment Period means a period during which a eligible individual who experiences certain one or more qualifying events may enroll in, or change enrollment under this Agreement outside of any Annual Open Enrollment Period.

Specialist means a licensed health care provider who is certified or trained in a specified field of medicine.

Specialty Drug means high-cost injectables, infused, oral or inhaled Prescription Drugs that:

A. Is prescribed for an individual with a complex or chronic medical condition or a rare medical condition, including but not limited to, the following: Hemophilia, Hepatitis C, Multiple Sclerosis, Infertility Treatment Management, Rheumatoid Arthritis, Psoriasis, Crohn's Disease, Cancer (oral medications), and Growth Hormones;

B. Costs $ 600 or more for up to the dispensing amount for non-Maintenance Drugs stated in the Schedule of Benefits

C. Is not typically stocked at retail pharmacies; and,

D. Requires:

1. A difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug; or

2. Enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

E. As used in this definition, the following terms have the meanings described below:

1. Complex or chronic medical condition means a physical, behavioral, or developmental condition that:

a) may have no known cure;

b) is progressive; or

c) can be debilitating or fatal if left untreated or undertreated.

2. Rare medical condition means a disease or condition that affects fewer than:

a) 200,000 individuals in the United States; or

b) approximately 1 in 1,500 individuals worldwide.

Spouse means a person of the same or opposite sex who is legally married to the Subscriber under the laws of the state or jurisdiction in which the marriage was performed. If the Academic Institution includes coverage of Dependents, a Spouse also includes a Domestic Partner, as defined in Section 2.3.

Step Therapy or Fail-First Protocol means a protocol established by CareFirst BlueChoice that requires a Prescription Drug or sequence of Prescription Drugs to be used by a Member before a Prescription Drug ordered by the Member's provider is covered.

Subscriber means the Eligible Student to whom this In-Network Agreement has been issued.

Substance Use Disorder means:

A. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or

B. Drug Use Disorder means a disease that is characterized by a pattern of pathological use

of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Substance Use Disorder Program means the CareFirst BlueChoice program for Members with a diagnosed Substance Use Disorder. The program includes ambulatory/outpatient detoxification, individual therapy, group therapy and medication assisted therapy.

Urgent Care means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the hospital emergency room. An Urgent Care facility is a freestanding facility that is not a physician's office and which provides Urgent Care.

Vision Care Designee means the entity with which CareFirst has contracted to administer Vision Care. [CareFirst's Vision Care Designee is [Davis Vision, Inc.].] [[Davis Vision, Inc.] is an independent company and administers the Vision Care benefits on behalf of CareFirst.]

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage.

A. The individual must be eligible for coverage either as a Subscriber or if applicable, as a Dependent;

B. The Subscriber and any Dependent, if applicable, must timely enroll as provided in Section 2.7 and CareFirst BlueChoice must receive Premium payments from the Academic Institution for each enrolled Member.

2.2 Eligibility for Student Health Center Services

A. The Academic Institution's student health center will determine who is eligible to receive Covered Services at the health center.

B. Dependents who are not Eligible Students may not be eligible to receive Covered Services at a student health center.

~~B.~~

~~2.2~~2.3 Eligibility of Subscriber's Spouse. If the Academic Institution has elected to include coverage for Dependents, then the Subscriber may enroll an individual that is his or her Spouse as a Dependent. A Subscriber cannot cover a former Spouse once divorced or if the marriage had been annulled. Premium changes resulting from the enrollment of a Spouse will be effective as determined by CareFirst BlueChoice.

~~2.3~~2.4 Eligibility of Subscriber's Domestic Partner. If the Academic Institution has elected to include coverage for Dependents, then the Subscriber may enroll an individual that is his or her eligible Domestic Partner. A Domestic Partner will be eligible for coverage to the same extent as a Subscriber's Spouse.

A. Requirements for Coverage. To be eligible for coverage as the Domestic Partner of a Subscriber, the following conditions must be met:

1. The individual must be eligible for coverage as a Domestic Partner as defined in Section 2.3(B);

2. The Subscriber must elect coverage for his/her Domestic Partner; and

3. Premium payments must be made as required under this Agreement.

B. Domestic Partnership means a relationship between a Subscriber and a Domestic Partner that satisfies the requirements of either section below:

1. The Subscriber and Domestic Partner are lawfully married under the laws of any state or are registered with any state or local government agency authorized to perform such registrations. There are no requirements for proof of relationship that are not also applied to any other married couple.

2. If the requirement in Section 2.3(B)(1) above has not been met, the Subscriber and Domestic Partner must meet all of the following requirements:

a) The Subscriber and the Domestic Partner are the same sex or opposite sex and both are at least eighteen (18) years of age and have the legal capacity to enter into a contract;

b) The Subscriber and the Domestic Partner are not parties to a legally recognized marriage with anyone else and are not in a civil union or

domestic partnership with anyone else;

c) The Subscriber and Domestic Partner are not related to the other by blood or marriage within four (4) degrees of consanguinity under civil law rule;

d) The Subscriber and Domestic Partner share a common primary residence. The Subscriber must submit one (1) of the following documents as proof of a shared common primary residence:

(1) Common ownership of the primary residence via joint deed or mortgage agreement;

(2) Common leasehold interest in the primary residence;

(3) Driver's license or State-issued identification listing a common address; or

(4) Utility or other household bill with both the name of the Subscriber and the Domestic Partner appearing; and

e) The Subscriber and Domestic Partner are Financially Interdependent, and submit documentary evidence of their committed relationship of financial interdependence, existing for at least six (6) consecutive months prior to application.

C. Financially Interdependent means the Subscriber and Domestic Partner can establish that they are in a committed relationship of mutual interdependence in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely. Financial Interdependence can be established by submitting documentation from any one (1) of the following criteria:

1. Joint bank account or credit account;

2. Designation of one partner as the other's primary beneficiary with respect to life insurance or retirement benefits.

3. Designation of one partner as the primary beneficiary under the other partner's will;

4. Mutual assignments of valid durable powers of attorney under the applicable laws of any state or the District of Columbia;

5. Mutual valid written advanced directives under the applicable laws of any state or the District of Columbia, approving the other partner as health care agent;

6. Join ownership or holding of investments; or

7. Joint ownership or lease of a motor vehicle.

~~2.4~~2.5 Eligibility of Children. If the Academic Institution has elected to include coverage for Dependents, then the Subscriber may enroll an individual that is an eligible Dependent Child. An individual who is the child of Domestic Partner is eligible for coverage as any other Dependent Child, if the Domestic Partner and the child of the Domestic Partner meet the qualifications for coverage. A Dependent Child means an individual who:

A. Is:

1. The natural child, stepchild, r adopted child or foster child of the Subscriber;

2. A child placed with the Subscriber, the Subscriber's Spouse or the Subscriber's eligible Domestic Partner for legal Adoption;

3. An individual under testamentary or court appointed guardianship, other than

temporary guardianship for less than twelve (12) months' duration, of the Subscriber, the Subscriber's Spouse or the Subscriber's eligible Domestic Partner; or

4. An unmarried grandchild who is in the court-ordered custody, and who resides with, and is a dependent of the Subscriber, the Subscriber's Spouse, or eligible Domestic Partner.

B. Is under the Limiting Age of twenty-six (26); or

C. Is an individual who is the subject of a Medical Child Support Order that creates or recognizes the right of the child to receive benefits under the health insurance coverage of the Subscriber, the Subscriber's covered Spouse or the Subscriber's covered Domestic Partner.

D. Premium changes resulting from the enrollment of a Dependent Child will be effective as determined by CareFirst.

~~2.5~~2.6 Limiting Age for Covered Dependent Children.

A. All covered Dependent Children are eligible up to the Limiting Age of twenty-six (26).

B. A covered Dependent Child will be eligible for coverage past the Limiting Age if, at the time coverage would otherwise terminate:

1. The Dependent Child is unmarried and is incapable of self-support or maintenance because of intellectual disability or physical handicap;

2. The Dependent Child is primarily dependent upon the Subscriber or the Subscriber's covered Spouse or Domestic Partner for support and maintenance;

3. The intellectual disability or physical handicap occurred before the covered Dependent Child reached the Limiting Age; and

4. The Subscriber provides CareFirst BlueChoice with proof of the Dependent Child's intellectual disability or physical handicap within thirty-one (31) days after the Dependent Child reaches the Limiting Age for Dependent Children. CareFirst BlueChoice has the right to verify whether the child is and continues to qualify as an incapacitated Dependent Child.

~~C. The coverage of a Dependent will terminate as provided in Section 4.2 if a Dependent Child reaches the Limiting Age or if there is a change in their status or relationship of the Dependent to the Subscriber, such that they no longer meet the eligibility requirements of this Agreement.~~

~~2.6~~2.7 Open Enrollment Opportunities and Effective Dates. Eligible individuals may elect coverage as a Subscriber or Member, as applicable, only during the Annual Enrollment Period or Special Enrollment Period.

A. Annual Open Enrollment. During an Annual Open Enrollment Period, an Eligible Student may enroll (or waive coverage, as applicable) as a Subscriber through the process specified by the Academic Institution and approved by CareFirst. Subscribers may also enroll eligible Dependents if the Academic Institution has elected to include coverage for Dependents through the process specified by the Academic Institution and approved by CareFirst BlueChoice.

B. Special Enrollment. If an eligible individual does not enroll during an Annual Open Enrollment Period, he or she may only enroll during a Special Enrollment Period:

1. An eligible individual may enroll as a Subscriber or Dependent, if the Academic

Institution has elected to include coverage for Dependents, upon the occurrence of one of the following qualifying events:

a. The eligible individual or a Dependent:

(1) Loses Minimum Essential Coverage. A loss of Minimum Essential Coverage~~includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii)~~. For example, those that are the result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, and reduction in the number of hours of employment.

Loss of coverage described herein includes those circumstances such as an employee or dependent who has coverage that is not COBRA continuation coverage; termination of employer contributions; or, exhaustion of COBRA continuation coverage Loss of coverage does not include voluntary termination of coverage or other loss due to:

(2) Failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA coverage; or

(3) Situations allowing for a Rescission.

b. Is enrolled in any non-Calendar Year health insurance policy even if the Qualified Individual or his or her Dependent has the option to renew non-Calendar Year health insurance policy. The date of the loss of coverage is the last day of the non-Calendar Year policy year.

c. Loses pregnancy-related coverage such as prenatal, delivery, and postpartum services. The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage; or

~~L~~ loses medically needy coverage as described only once per calendar year. The date of the loss of coverage is the last day the consumer would have medically needy coverage

d. The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation or if the enrollee or his or her Dependent dies.

e. Loses coverage as a result of spouse moving to a Medicare plan resulting in the loss of coverage for eligible individual.

f. An eligible individual gains, or becomes, if the Academic Institution has elected to include coverage for Dependents, a Dependent, through marriage, domestic partnership, birth, adoption, placement for adoption, grant of court or testamentary guardianship, child support order (MCSO) or other court order, or placement of a child for foster care. The foster child is not eligible for coverage under this Agreement.

g. In the case of marriage, at least one Spouse must demonstrate that he or she:

(1) had minimum essential coverage for one or more days during the sixty (60) days preceding the date of marriage or demonstrates that he or she had pregnancy related coverage, had access to healthcare related services through unborn child coverage, or had medically needy coverage; or,

(2) was living in a foreign country or in a United States territory for one or more days during the sixty (60) days preceding the date of marriage;

or,

(3) ~~(3)~~ is an Indian as defined by section 4 of the Indian Health Care Improvement Act; or,

(4) ~~(4)~~ lived for one (1) or more days during the sixty (60) days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no qualified health plan was available.

h. ~~c.~~ Within 6 months after the death of a spouse, a Subscriber may exercise the addition of a Subscriber's dependent children to the Agreement.

~~d~~i. The eligible individual or his or her Dependent become eligible as a result of a permanent move and either:

(1) (1) ~~(1)~~ had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the sixty (60) days preceding the date of the permanent move; or,

(2) was living in a foreign country or in a United States territory at the time of the permanent move.

(3) lived for one (1) or more days during the sixty (60) days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no qualified health plan was available; or

(4) is an Indian as defined by Section 4 of the Indian Health Care Improvement Act.

The eligible individual or his or her Dependent may access this Special Enrollment Period sixty (60) days before or after the date of the permanent move.

j. The eligible individual is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B-2T, or a Dependent or unmarried victim within a household, who is enrolled in minimum essential coverage and sought to enroll in coverage separate from the perpetrator of the abuse or abandonment. A Dependent of a victim of domestic abuse or spousal abandonment on the same application as the victim may enroll in coverage at the

k. If an eligible individual did not timely enroll during an Annual Open Enrollment Period or during the time period specified by the Academic Institution because he or she already had coverage under an employer sponsored health plan or a group health benefits plan, he or she may enroll as a Subscriber or Dependent, if the Academic Institution has elected to include coverage for Dependents, under this Agreement due to any of the following qualifying events:

l. Termination (other than by reason of such employee's gross misconduct) of the employee covered under the other employer sponsored plan or group health benefits plan.

~~a) The eligible individual or a Dependent:~~

~~(1) Loses Minimum Essential Coverage. A loss of Minimum Essential Coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii).~~

~~Loss of coverage described herein includes those circumstances~~

described in 26 CFR 54.9801-6(a)(3)(i) through (iii) and in paragraphs (d)(1)(ii) through (iv) of 45 CFR §155.420. Loss of coverage does not include voluntary termination of coverage or other loss due to:

(a) Failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA coverage; or

(b) Situations allowing for a Rescission.

(2) Loses pregnancy-related coverage described in 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) or loses access to health care services through coverage provided to a pregnant woman's unborn child, based on the definition of a child in 42 CFR 457.10. The date of the loss of coverage is the last day the qualified individual would have pregnancy-related coverage or access to health care services through the unborn child coverage; or

(3) Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year. The date of the loss of coverage is the last day the consumer would have medically needy coverage.

(4) Loses coverage or eligibility rights as determined by the Academic Institution.

(5) The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation or if the enrollee or his or her Dependent dies.

(6) Loses coverage as a result of spouse moving to a Medicare plan resulting in the loss of coverage for eligible individual

b) An eligible individual gains, or becomes, if the Academic Institution has elected to include coverage for Dependents, a Dependent, through marriage, domestic partnership, birth, adoption, placement for adoption, grant of court or testamentary guardianship, child support order (MCSO) or other court order, or placement of a child for foster care. The foster child is not eligible for coverage under this Agreement. At least one Spouse must demonstrate having minimum essential coverage for one or more days during the sixty (60) days preceding the date of marriage unless one Spouse can demonstrate that he or she lived in a foreign country or in a US territory for one (1) or more days during the sixty (60) days preceding the marriage

c) Within 6 months after the death of a spouse, a Subscriber may exercise the addition of a Subscriber's dependent children to the Agreement.

d) The eligible individual or his or her Dependent becomes eligible as a result of a permanent move and:

(1) had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the sixty (60) days preceding the date of the permanent move; or,

(2) was living in a foreign country or in a United States territory for one (1) or more days during the sixty (60) days preceding the date of the permanent move.

(3) lived for one (1) or more days during the sixty (60) days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no qualified health plan was available.

The eligible individual or his or her Dependent may access this Special Enrollment Period sixty (60) days before or after the date of the permanent move.

e) The eligible individual is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B-2T, or a Dependent or unmarried victim within a household, who is enrolled in minimum essential coverage and sought to enroll in coverage separate from the perpetrator of the abuse or abandonment. A Dependent of a victim of domestic abuse or spousal abandonment on the same application as the victim may enroll in coverage at the same time as the victim.

f) The eligible individual or his or her Dependent becomes eligible for coverage as a result of a release from incarceration

2. If an eligible individual did not timely enroll during an Annual Open Enrollment Period or during the time period specified by the Academic Institution because he or she already had coverage under an employer sponsored health plan or a group health benefits plan, he or she may enroll as a Subscriber or Dependent, if the Academic Institution has elected to include coverage for Dependents, under this In-Network Agreement due to any of the following qualifying events:

a) Death of the employee covered under the other employer sponsored plan or group health benefits plan.

b) Termination (other than by reason of such employee's gross misconduct) of the employee covered under the other employer sponsored plan or group health benefits plan.

c) The divorce or legal separation of the eligible individual from his or her Spouse who was the employee covered under the other employer

~~sponsored plan or group health benefits plan.~~

~~d) The employee covered under the other employer sponsored plan or group health benefits plan becomes eligible for benefits under Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq.~~

~~e) The eligible individual or eligible Dependent is a dependent child who ceased to be a dependent child under the generally applicable requirements of the other employer sponsored plan or group health benefits plan.~~

~~f) The employee covered under the other employer sponsored plan or group health benefits plan lost coverage as a result of a proceeding in a case under title 11, commencing after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time. In the case of an event described in this subparagraph, "lost coverage" includes a substantial elimination of coverage with respect to a qualified beneficiary as described in 29 U.S.C. § 1167(3)(c) within one year before or after the date of the commencement of the proceeding.~~

~~C. With the exception of the qualifying events described in Section 2.6B.1. a)and c) and Section 2.6B2, the Special Enrollment Period for the qualifying events listed in Section 2.6B shall be the sixty (60) day period from the date of the qualifying event. In the case of a qualifying event under 2.B.1.a) and 2.6B.2, the Special Enrollment Period shall be the sixty (60) days before and after the loss of coverage. In the case of a qualifying event under Section 2.6B.1.c), the Special Enrollment Period shall be within 6 months after the death of a spouse.~~

~~D.~~C. Effective Dates.

1. Annual Open Enrollment Effective Dates. The Effective Date for an eligible individual who timely enrolls during an Annual Open Enrollment Period is the first day of the Contract Year, or the first day of the semester applicable to that Annual Open Enrollment Period as specified by the Academic Institution and approved by CareFirst BlueChoice.

2. The Effective Date for a Dependent Child who timely enrolls during a Special Enrollment Period is the Dependent Child's First Eligibility Date:

   a) First Eligibility Date means:

      (1) For a newborn Dependent Child, the child's date of birth;

      (2) For a newly adopted Dependent Child, the earlier of:

         (a) A judicial decree of Adoption; or

         (b) Placement of the child in the Subscriber's home as the legally recognized proposed adoptive parent; or,

      (3) For a Dependent Child for whom guardianship has been granted by court or testamentary appointment or the date of the appointment.

      (4) For a child placed for foster care, the date of placement of the child by the foster care agency. The foster child is not eligible for coverage under this In-Network Agreement.

(5) For a child subject to a child support order (MCSO or other court order), the date of the child support order.

b) The Dependent Child will be covered automatically, but only for the first thirty-one (31) days following the child's First Eligibility Date. The Subscriber must enroll such a Dependent Child within sixty (60) days of the child's First Eligibility Date when an additional premium is due for the enrollment of the Dependent Child. Otherwise, the Dependent Child will not be covered and cannot be enrolled until the next Annual Open Enrollment Period. (An additional premium will be due unless there are three (3) or more Dependent Children under the age of twenty-one (21) already enrolled by the Subscriber).

3. The Effective Date for a Spouse who becomes a new Dependent and who timely enrolls during a Special Enrollment Period shall be the first day of the month following the receipt of enrollment by CareFirst BlueChoice.

4. The Effective Date for an eligible individual or Dependent who loses other Minimum Essential Coverage who timely enrolls during a Special Enrollment Period shall be the first day of the month following the receipt of enrollment by CareFirst BlueChoice.

5. The Effective Date for an individual who becomes a newly Eligible Subscriber will be the date as determined by CareFirst.

6. In all other cases, the Effective Date for an individual or Dependent who timely enrolls during a Special Enrollment Period will be:

a) For enrollment received by CareFirst BlueChoice between the first and the fifteenth day of the month, the first day of the following month; and

b) For enrollment received by CareFirst BlueChoice between the sixteenth and the last day of the month, the first day of the second following month.

7. Premium changes resulting from the enrollment of a Subscriber or a Dependent during a Special Enrollment Period will be effective as determined by CareFirst BlueChoice.

~~E.~~D. A Dependent of an eligible individual is not eligible for a Special Enrollment Period if the Academic Institution does not extend the offer of coverage to Dependents.

~~2.7~~2.8 Medical Child Support Orders (MCSO or QMSO). This provision does not apply if the Academic Institution does not extend the offer of coverage to Dependents.

A. Eligibility and Termination.

1. Upon receipt of an MCSO or QMSO, CareFirst BlueChoice will accept enrollment of a child that is the subject of an MCSO or QMSO. Coverage will be effective as of the date of the order, and the Premium will be adjusted as needed. If the Subscriber does not enroll the child then CareFirst BlueChoice will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any state or the District of Columbia. If the Subscriber is subject to a Waiting Period, the child will not be enrolled until the end of the Waiting Period.

2. Enrollment for such a child will not be denied because the child:

a) Was born out of wedlock;

b) Is not claimed as a dependent on the Subscriber's federal tax return;

c) Does not reside with the Subscriber; or

d) Is covered under any Medical Assistance or Medicaid program.

3. Coverage required by an MCSO or QMSO will be effective as of the date of the order.

4. Termination. Unless coverage is terminated for non-payment of the Premium, a covered child subject to an MCSO or QMSO may not be terminated unless written evidence is provided to CareFirst stating:

a) The MCSO or QMSO is no longer in effect; or

b) The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the date of the termination of coverage.

c) The Academic Institution has eliminated family members' coverage for all its students; or

d) The insuring parent is no longer an Eligible Student.

B. Administration**.** When the child subject to an MCSO or QMSO does not reside with the Subscriber, CareFirst BlueChoice will:

1. Send to the non-insuring custodial parent the identification cards, claims forms, the applicable Agreement and any information needed to obtain benefits;

2. Allow the non-insuring custodial parent or a provider of a Covered Service to submit a claim without the approval of the Subscriber; and

3. Provide benefits directly to:

a) The non-insuring parent;

b) The provider of the Covered Services, Covered Dental Services or Covered Vision Services;

c) The appropriate child support enforcement agency of any state or the District of Columbia; or

d) The Department of Medical Assistance Services, as the payor of last resort.

~~2.8~~2.9 Clerical or Administrative Error. If an individual is ineligible for coverage, the individual cannot become eligible just because CareFirst BlueChoice made a clerical or administrative error in recording or reporting information. Likewise, if a Member is eligible for coverage, the Member will not lose coverage because CareFirst BlueChoice o made an administrative or clerical error in recording or reporting information.

~~2.9~~2.10 Cooperation and Submission of Information. The Subscriber agrees to cooperate with and assist CareFirst BlueChoice , including providing CareFirst BlueChoice with reasonable access to eligibility records upon request. At any time that coverage is in effect, CareFirst BlueChoice reserves the right to request documentation substantiating eligibility.

Knowingly attempting to obtain, or actually obtaining eligibility for any person known to the Subscriber to be ineligible pursuant to the eligibility provisions stated in this In-Network Agreement, shall constitute an act or practice constituting fraud or an intentional misrepresentation of material fact and in addition to the remedies related to Rescission provided in this In-Network Agreement, CareFirst BlueChoice reserves to itself any and all rights provided by law for such act or acts.

SECTION 3
PREMIUMS AND PAYMENT

3.1. Premiums. All Premiums shall be paid to CareFirst BlueChoice by the Academic Institution. The initial Premium is due to CareFirst BlueChoice on the date as determined by CareFirst BlueChoice. It is the obligation of the Academic Institution to remit payment to CareFirst, BlueChoice as such obligations are described in the Academic Institution Contract between CareFirst BlueChoice and the Academic Institution

If the Academic Institution elects an electronic payment, CareFirst BlueChoice will not debit or charge the amount of the Premium due prior to the Premium Due Date, except as authorized by the Academic Institution.

3.2 Grace Period.

All Premiums shall be paid to CareFirst BlueChoice by the Academic Institution. Except for the initial Premium(s), there is a grace period of 31 days within which overdue Premiums can be paid without loss of coverage. The 31-day grace period begins on the Premium Due Date. The grace period will be granted for the payment of each Premium by the Academic Institution falling due after the first Premium. This Agreement shall continue in force during the grace period.

If Premiums have not been received by the Premium Due Date, CareFirst Blue Choice will notify the Academic Institution in writing of the overdue Premiums. If CareFirst receives payment by the Academic Institution of all amounts listed on the notice prior to the end of the 31-day grace period, coverage will continue without interruption. If CareFirst BlueChoice does not receive full payment by the Academic Institution prior to the end of the grace period, the Subscriber's and any Member's coverage will terminate effective as of midnight on the last day of the grace period. No additional Premiums will be charged for the time coverage continued in force under the grace period.

3.3 Reinstatement. A Subscriber may apply for reinstatement of a terminated policy if the Subscriber believes the policy was terminated due to an error by CareFirst. All reinstatement requests must be approved by the Exchange and may be declined. Under no circumstances will CareFirst or the Exchange automatically reinstate a terminated policy.

~~A. If any Premium is not paid in full by the Academic Institution within the time granted the Subscriber for payment, a later acceptance of Premium in full by CareFirst BlueChoice or by any agent authorized by CareFirst BlueChoice to accept the Premium, without requiring a reinstatement application in connection with the acceptance of the Premium in full, shall reinstate the Agreement.~~

~~B. If CareFirst BlueChoice or the agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Agreement will be reinstated upon approval of the application by CareFirst BlueChoice or, lacking approval, upon the forty-fifth (45th) day following the date of the conditional receipt unless CareFirst BlueChoice has previously notified the Academic Institution in writing of its disapproval of the reinstatement application.~~

~~C. The Academic Institution and CareFirst BlueChoice shall have the same rights under the reinstated Agreement as they had under the Agreement immediately before the due date of the defaulted Premium, subject to any provisions contained within the Agreement in connection with the reinstatement.~~

~~D. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.~~

3.4 Premium Adjustments. All Premium adjustments for Members enrolling or terminating during a coverage month will be made by CareFirst BlueChoice.

3.5 Premium Rate Changes. There may be a Premium rate change when approved by the District of Columbia Department of Insurance, Securities and Banking, as provided by law. CareFirst BlueChoice will not increase the Subscriber's Premium more frequently than once every Contract Year. CareFirstBlueChoice will provide notice of the change to Premiums by giving the Academic Institution at least sixty (60) days prior written notice. Any change in Premium rates, including changes in a Member's Premium rate due to a change in a Member's age, will be effective on the effective date each Contract Year when this Agreement renews.

CareFirstBlueChoice may change the Premium during a Contract Year if the change is due solely to a mistake impacting the Premium rate or due to the enrollment or termination of a Dependent.

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Agreement.

A. The Agreement shall terminate if Premium has not been paid in full by the Academic Institution.

B. The Subscriber may terminate the Agreement if coverage is no longer required by the Academic Institution.

C. Termination of Subscriber's enrollment at the Academic Institution. The Subscriber's and any Dependent's coverage will be terminated as follows if the Subscriber is no longer enrolled in the Academic Institution:

1. If termination of enrollment at the Academic Institution occurs during the first six (6) months of the Benefit Period, coverage will end at the end of the first six (6) months of Benefit Period.

2. If termination of enrollment at the Academic Institution occurs during the second six (6) months of the Benefit Period, coverage will continue until the end of the Benefit Period.

3. The Subscriber may request an earlier termination under Section 4.1C if no longer enrolled in the Academic Institution. If an earlier termination date is requested, Premiums will be refunded on a pro-rata basis, as applicable. The Subscriber is required to notify the Academic Institution of termination under Section 4.1C.3, and the Academic Institution is required to issue any applicable refund.

D. The Academic Institution must provide written notification to CareFirst BlueChoice of any such terminations under Section 4.1.A through 4.1.C. Termination shall be without prejudice to any claim originating prior to the effective date of the cancellation.

~~E.~~ Termination of Dependent Coverage. ~~If the Academic Institution extends the offer of coverage to Dependents:~~

E.

1. For all Dependents, coverage will terminate on the same date that coverage terminates for the Subscriber.

2. Except for a Dependent Child reaching the Limiting Age, a Dependent's coverage will terminate at the [end of month][end of the semester] [end of the Benefit Period]in which the Dependent became no longer eligible if there is a change in their status or relationship to the Subscriber, such that they no longer meet the eligibility requirements of this Agreement.

3. For a Dependent Child reaching the Limiting Age, coverage will terminate at the [end of month][end of the semester] [end of the Benefit Period] in which the Dependent reaches the Limiting Age.

The Subscriber is responsible for notifying the Academic Institution of any changes in the status of a Dependent which affects his or her eligibility for coverage under this Agreement, and the Academic Institution will notify CareFirst BlueChoice. These changes include a death or divorce. If the Subscriber does not notify the Academic Institution of these types of changes and it is later determined that a Dependent was not eligible for coverage, CareFirst BlueChoice may rescind the Agreement and recover the full value of the services and benefits provided during the period of ineligibility if fraud or intentional misrepresentation was involved in the failure to provide notification of any changes in the status of a Dependent which affects his or her eligibility under this

Agreement.

F CareFirst BlueChoice elects not to renew all of its individual health benefit plans in the state or jurisdiction. In this case, CareFirst BlueChoice:

1. Shall give notice of this decision to all affected individuals at least one hundred eighty (180) days before the effective date of non-renewal; and

2. Shall give notice to all affected individuals at least one hundred eighty (180) days before the effective date of non-renewal of the individual's option to purchase all other individual health benefit plans currently offered by an affiliate of CareFirst.

.

4.2 Rescission of Enrollment for Fraud or Misrepresentation. This Agreement, or the enrollment of a Member, may be Rescinded if:

A. The Member has performed an act, practice, or omission that constitutes fraud;

B. The Member has made an intentional misrepresentation of material fact; or

C. An act, practice or omission that constitutes fraud includes, but is not limited to, fraudulent use of CareFirst's identification card by the Member, the alteration or sale of prescriptions by the Member, or an attempt by a Subscriber to enroll non-eligible persons.

CareFirst BlueChoice will provide thirty (30) days advance written notice of any Rescission. CareFirst shall have the burden of persuasion that its Rescission complies with applicable state law. The Rescission shall either (i) void the enrollment of the Member and any benefits paid as of the Member's Effective Date (for fraudulent acts, practices, or omissions that occur at the time of enrollment); or (ii) in all other cases, void the enrollment of the Member and any benefits paid as of the first date the Member performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of material fact. The Subscriber will be responsible for payment of any voided benefits paid by CareFirst BlueChoice , net of applicable Premiums paid. Any Premiums paid from the date of coverage being voided or Rescinded will be refunded to the Subscriber.

4.3 Cancellation of Dependent Coverage by the Subscriber.

A. Except as provided in paragraph 4.4B, the Subscriber may terminate the coverage of an eligible Dependent. The effective date of the termination will be the [end of month] [end of the semester] [end of the Benefit Period]of the receipt by CareFirst BlueChoice of the notice of termination from the Academic Institution. If coverage is terminated under this Section, CareFirst BlueChoice will not be required to give notice of termination to the Subscriber or to the Dependents.

B. If a Dependent Child is enrolled under this Agreement pursuant to a MCSO, as described in Section 2.7, the Subscriber may not terminate or cancel the coverage of such child except as specifically provided in Section 2.7.

4.4 Death of Dependent. In case of the death of a Dependent, the enrollment of the deceased Dependent shall terminate as of the date of the Dependent's death.

4.5 Death of Subscriber. In case of the death of the Subscriber, this Agreement shall terminate on the date of the Subscriber's death if there are no Dependents enrolled under this Agreement. If Dependents are enrolled, this Agreement shall terminate on the last day of the month in which the Subscriber's death occurs.

4.6 Effect of Termination. No benefits will be provided for any services received on or after the date

on which this Agreement terminates. This includes services received for an injury or illness that occurred before the date of termination.

SECTION 5
COORDINATION OF BENEFITS (COB)

5.1 Coordination of Benefits (COB).

A. Applicability.

1. This Coordination of Benefits (COB) provision applies to this CareFirst BlueChoice Plan when a Member has health care coverage under more than one Plan.

2. If this COB provision applies, the Order of Benefit Determination Rules should be reviewed first. Those rules determine whether the benefits of this CareFirst BlueChoice Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:

a) Shall not be coordinated when, under the order of determination rules, this CareFirst Plan determines its benefits before another Plan;

b) May be coordinated when, under the order of determination rules, another Plan determines its benefits first. The coordination is explained in Section 5.1D.2.

B. Definitions. For the purpose of this COB section, the following terms are defined. The definitions of other capitalized terms are found in the definitions section of this Agreement.

Allowable Expenses means any health care expense, including deductibles, coinsurance or copayments that are covered in whole or in part by any of the Plans covering the Member. This means any expense or portion of an expense not covered by any of the Plans is not an Allowable Expense. If this CareFirst BlueChoice Plan is advised by a Member that all Plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account, the primary Plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible, as stated in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

CareFirst BlueChoice Plan means this In-Network Agreement.

Intensive Care Policy means a health insurance policy that provides benefits only when treatment is received in a specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

Plan means any health insurance policy, including those of a nonprofit health service plan, those of a commercial, group, and blanket policy, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage required or provided by law and coverage under a governmental plan, except a governmental plan which, by law, provides benefits in excess of those of any private insurance plan or other non-governmental plan. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

The term Plan does not include:

1. An individually underwritten and issued, guaranteed renewable, specified disease policy;

2. An intensive care policy, which does not provide benefits on an expense incurred basis;

3. Coverage regulated by a motor vehicle reparation law;

4. The first one-hundred dollars ($100) per day of a hospital indemnity contract; or

5. An elementary and/or secondary school insurance program sponsored by a school or school system.

Primary Plan or Secondary Plan means the order of benefit determination rules stating whether this CareFirst BlueChoice Plan is a Primary Plan or Secondary Plan as to another Plan covering the Member.

1. When this CareFirst BlueChoice Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

2. When this CareFirst BlueChoice Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be coordinated because of the other Plan's benefits.

3. When there are more than two Plans covering the Member, this CareFirst BlueChoice Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Specified Disease Policy means a health insurance policy that provides (1) benefits only for a disease or specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease specified in the policy or for treatment unique to a specified disease.

C. Order of Benefit Determination Rules.

1. General. When there is a basis for a claim under this CareFirst BlueChoice Plan and another Plan, this CareFirst BlueChoice Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

   a) The other Plan has rules coordinating benefits with those of this CareFirst BlueChoice Plan; and

   b) Both those rules and this CareFirst Plan's rules require this CareFirst BlueChoice Plan's benefits be determined before those of the other Plan.

2. Rules. This CareFirst BlueChoice Plan determines its order of benefits using the first of the following rules which applies:

   a) Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

      (1) Secondary to the Plan covering the person as a dependent, and

      (2) Primary to the Plan covering the person as other than a dependent (e.g., retired employee),

Then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

b) Dependent Child covered by more than one Plan. Unless there is a court decree stating otherwise, when this CareFirst BlueChoice Plan and another Plan cover the same child as a dependent, the order of benefits shall be determined as follows:

(1) For a Dependent Child whose parents are married or are living together:

(a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but

(b) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

(2) For a Dependent Child whose parents are separated, divorced, or are not living together:

(a) If the specific terms of a court decree state one of the parents is responsible for the health care expenses or health care coverage of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with responsibility has no health care coverage for the Dependent Child's health care expenses, but the parent's Spouse does, that parent's Spouse's plan is the primary plan. This paragraph does not apply with respect to any claim for services rendered before the entity has actual knowledge of the terms of the court decree.

The rule described in (1) above also shall apply if: i) a court decree states both parents are responsible for the Dependent Child's health care expenses or health care coverage, or ii) a court decree states the parents have joint custody without specifying one parent has responsibility for the health care expenses or coverage of the Dependent Child.

(b) If there is no court decree setting out the responsibility for the child's health care expenses or health care coverage, the order of benefits for the Dependent Child are as follows:

i) The Plan of the parent with custody of the child;

ii) The Plan of the Spouse of the parent with the custody of the child;

iii) The Plan of the parent not having custody of the child; and then

iv) The Plan of the Spouse of the parent who does not have custody of the child.

(3) For a Dependent Child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the rules stated in (1) and (2) of this paragraph as if those individuals were parents of the child.

c) Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired is determined before those of a Plan that covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as an employee who is neither laid off nor retired or a person covered as a laid off or retired employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

d) Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefits determination:

(1) First, the benefits of a Plan covering the person as an employee, retiree, member or subscriber (or as that person's dependent);

(2) Second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

e) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter term.

D. Effect on the Benefits of this CareFirst BlueChoice Plan.

1. When this Section Applies. This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst BlueChoice Plan is a Secondary Plan as to one or more other Plans. In such an event, the benefits of this CareFirst BlueChoice Plan may be coordinated under this section. Any additional other Plan or Plans are referred to as "the other Plans" immediately below.

2. Coordination in this CareFirst BlueChoice Plan's Benefits. When this CareFirst BlueChoice Plan is the Secondary Plan, the benefits under this CareFirst Plan *may* be coordinated so that the total benefits that would be payable or provided by all the other Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. If the benefits of this CareFirst Plan are coordinated, each benefit is coordinated in proportion. It is then charged against any applicable benefit limit of this CareFirst BlueChoice Plan.

E. Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. CareFirst BlueChoice has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. CareFirst BlueChoice need

not tell, or get the consent of, any person to do this. Each person claiming benefits under this CareFirst BlueChoice Plan must give this CareFirst BlueChoice Plan any facts it needs to pay the claim.

F. Facility of Payment. A payment made under another Plan may include an amount that should have been paid under this CareFirst BlueChoice Plan. If it does, this CareFirst BlueChoice Plan may pay the amount to the organization that made that payment. The amount will then be treated as though it were a benefit paid under this CareFirst BlueChoice Plan. This CareFirst BlueChoice Plan will not have to pay the amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery. If the amount of the payments made by this CareFirst BlueChoice Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;

2. Insurance companies; or

3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

5.2 Medicare Eligibility. This provision applies to Members who are entitled to Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of sixty-five (65) or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in the Agreement. Benefits covered by Medicare are subject to the provisions in this section.

A. Coverage Secondary to Medicare. Except where prohibited by law, the benefits under this CareFirst BlueChoice Plan are secondary to Medicare.

B. Medicare as Primary.

1. When benefits for Covered Services, Covered Dental Services or Covered Vision Services are paid by Medicare as primary, this CareFirst BlueChoice Plan will not duplicate those payments. CareFirst BlueChoice will coordinate and pay benefits based on Medicare's payment (or the payment Medicare would have paid). When CareFirst BlueChoice coordinates the benefits with Medicare, CareFirst' BlueChoice s payments will be based on the Medicare allowance (if the provider is a participating provider in Medicare) or the Medicare maximum limiting charge (if the provider is not a participating provider in Medicare), less any claim reduction or denial due to a Member's failure to comply with Medicare's administrative requirements. CareFirst BlueChoice's right to coordinate is not contingent on any payment actually being made on the claim by Medicare. Members enrolled in Medicare agree to, and shall, complete and submit to Medicare, CareFirst BlueChoice, and/or any health care providers all claims, consents, releases, assignments and other documents required to obtain or assure such claim payment by Medicare.
2. If a Medicare-eligible Member has not enrolled in Medicare Part A and/or Part B, CareFirstBlueChoice will not "carve-out," coordinate, or reject a claim based on the amount Medicare would have paid had the Member actually applied for, claimed, or received Medicare benefits.

5.3 Employer or Governmental Benefits. Coverage does not include the cost of services or payment for

services for any illness, injury, or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:

A. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or

B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the United States Department of Veterans Affairs, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

5.4 Subrogation

A. CareFirst has subrogation and reimbursement rights. Subrogation requires the Member to turn over to CareFirst any rights the Member may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a Member for an injury or illness. Subrogation applies to any illness or injury which is:

1. Caused by an act or omission of a third party; or

2. Covered under a member's uninsured or underinsured policy issued to or otherwise covering the Member; or

3. Covered by No Fault Insurance. No Fault Insurance means motor vehicle casualty insurance. This term also refers to motor vehicle insurance issued under any other state or federal legislation of similar purpose.

B. If the Member receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or need for care for which benefits were provided or will be provided under this Agreement, the payment will be treated as having been paid to the Member as a recovery for the medical, hospital and other expenses for which CareFirst provided or will provide benefits. CareFirst may recover the amounts paid or will pay in benefits up to the amount received from or on behalf of the third party or applicable first party coverage.

All recoveries the Member or the Member's representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated (for example as "pain and suffering"), must be used to reimburse CareFirst in full for benefits paid. CareFirst's share of any recovery extends only to the amount of benefits paid or payable to the Member, the Member's representatives, and/or health care providers on the Member's behalf. For purposes of this provision, "Member's representatives" include, if applicable, heirs, administrators, legal representatives, parents (if the Member is a minor), successors, or assignees. This is CareFirst's right of recovery.

C. CareFirst's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. If required by law, CareFirst will reduce the amount owed by the Member to CareFirst in accordance with applicable law.

D. CareFirst will have a lien on all funds the Member recovers up to the total amount of benefits provided. We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. CareFirst may give notice of that lien to any party who may have contributed to the Member's loss, or who may be liable for payment as a result of that loss.

E. CareFirst has the option to be subrogated to the Member's rights to the extent of the benefits provided under this Agreement. This includes CareFirst right to bring suit or file claims against the third party in the Member's name.

F. Members agree to take action, furnish information and assistance, and execute such instruments that CareFirst may require while enforcing CareFirst rights under this Section. The Member

agrees to not take any action which prejudices CareFirst's rights and interests under this provision.

~~A. CareFirst BlueChoice has subrogation and reimbursement rights. Subrogation requires the Member to turn over to CareFirst BlueChoice any rights the Member may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a Member for an injury or illness. Subrogation applies to any illness or injury which is:~~

~~1. Caused by an act or omission of a third party; or~~

~~2. Covered under a member's uninsured or underinsured policy issued to or otherwise covering the Member; or~~

~~3. Covered by No Fault Insurance.~~ No Fault Insurance ~~means motor vehicle casualty insurance. This term also refers to motor vehicle insurance issued under any other state or federal legislation of similar purpose.~~

~~B. If the Member receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or need for care for which benefits were provided or will be provided under this Agreement, the payment will be treated as having been paid to the Member as a recovery for the medical, hospital and other expenses for which CareFirst BlueChoice provided or will provide benefits. CareFirst BlueChoice may recover the amounts paid or will pay in benefits up to the amount received from or on behalf of the third party or applicable first party coverage.~~

~~C. CareFirst BlueChoice's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. If required by law, CareFirst BlueChoice will reduce the amount owed by the Member to CareFirst BlueChoice in accordance with applicable law.~~

~~D. CareFirst BlueChoice will have a lien on all funds the Member recovers up to the total amount of benefits provided. We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. CareFirst BlueChoice may give notice of that lien to any party who may have contributed to the Member's loss, or who may be liable for payment as a result of that loss.~~

~~E. CareFirst BlueChoice has the option to be subrogated to the Member's rights to the extent of the benefits provided under this Agreement. This includes CareFirst BlueChoice right to bring suit or file claims against the third party in the Member's name.~~

~~F. Members agree to take action, furnish information and assistance, and execute such instruments that CareFirst BlueChoice may require while enforcing CareFirst BlueChoice rights under this Section. The Member agrees to not take any action which prejudices CareFirst BlueChoice's rights and interests under this provision.~~

SECTION 6
GENERAL PROVISIONS

6.1 Entire Agreement; Changes. Entire Agreement; Changes. The entire agreement between CareFirst BlueChoice and the Academic Institution includes: (a) the Academic Institution Contract; (b) the In-Network Student Health Plan Individual Enrollment Agreement; (c) [the Benefit Determinations and Appeals Attachment]; (d) the Description of Covered Services; (e) the In-Network Schedule of Benefits; and (f) any additional duly authorized notices, amendments and riders.
No amendment or modification of any term or provision of this Agreement shall be valid until approved by an executive officer of CareFirstBlueChoice. Any duly authorized notice, amendment or rider will be issued by CareFirst BlueChoice to be attached to the Agreement. No agent has authority to change this Agreement or to waive any of its provisions. Any waiver of to the In-Network Agreementterm or provision shall only be given effect for its stated purpose and shall not constitute or imply any subsequent waiver.

Oral statements cannot be relied upon to modify or otherwise affect the benefits, limitations and/or exclusions of this Agreement, or increase or void any coverage or reduce any benefits under this Agreement. Such oral statements cannot be used in the prosecution or defense of a claim.

6.2 Claims and Payment of Claims.

A. Claim Forms. A claim form can be requested by calling the Member and Provider Service telephone number on the identification card during regular business hours. CareFirst BlueChoice shall provide claim forms for filing proof of loss to each claimant. If CareFirst BlueChoice does not provide the claim forms within fifteen (15) days after notice of claim is received, the claimant is deemed to have complied with the requirements of the policy as to proof of loss if the claimant submits, within the time fixed in the policy for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

When a child subject to a Medical Child Support Order or a Qualified Medical Support Order does not reside with the Subscriber, CareFirst BlueChoice will:

1. Send the non-insuring, custodial parent identification cards, claims forms, the applicable certificate of coverage or member contract, and any information needed to obtain benefits;

2. Allow the non-insuring, custodial parent or a provider of a Covered Service to submit a claim without the approval of the Subscriber; and

3. Provide benefits directly to:

   a) The non-insuring, custodial parent;

   b) The provider of the Covered Services, Covered Dental Services, or Covered Vision Services;

   c) The appropriate child support enforcement agency of any state or the District of Columbia; or

   d) The Department of Medical Assistance Services, as the payor of last resort.

B. Proof of Loss.

For Covered Services provided by Contracting Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacies, Members are not required to submit claims in order to obtain benefits.

For Covered Services provided by Non-Participating Providers, Non-Participating Dentists, Non-Contracting Vision Providers, and Non-Contracting Pharmacies, Members must furnish written proof of loss, or have the provider submit proof of loss, to CareFirst BlueChoice within two (2) years from the time proof is otherwise required. Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

CareFirst BlueChoice will honor claims submitted for Covered Services, Covered Dental Services or Covered Vision Services by any agency of the federal, state or local government that has the statutory authority to submit claims beyond the time limits established under this Agreement. These claims must be submitted to CareFirst BlueChoice before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst BlueChoice deems necessary to process the claims. CareFirst BlueChoice provides forms for this purpose.

C. Time of Payment of Claims. Except as provided in this paragraph, benefits payable will be paid not more than sixty (60) days after receipt of written proof of loss. Claims for services rendered after expiration of the first month of the grace period for recipients of Advance Payments of the Premium Tax Credit, as set forth in Sections 3.2B. and 4.2B.2., will be pended and will only be paid after the Subscriber makes payment of the Premium due. Any accrued benefits unpaid at the Member's death shall be paid to the Member's estate.

D. Claim Payments Made in Error. If CareFirst BlueChoice makes a claim payment to the Member in error, the Member is required to repay CareFirst the amount that was paid in error. If the Member has not repaid the full amount owed CareFirst BlueChoice and CareFirst BlueChoice makes a subsequent benefit payment to the Member, CareFirst may subtract the amount owed CareFirst BlueChoice from the subsequent payment to the Member. If CareFirst BlueChoice makes a claim payment to a provider in error, any overpayment shall be repaid by that provider and shall not be the responsibility of the Member.

E. Payment of Claims. Payments for Covered Services will be made by CareFirst BlueChoice directly to Contracting Vision, Participating and Preferred Dentists and Preferred Providers. If a Member receives Covered Services from Non-Contracting Vision or Non-Preferred Providers, CareFirst BlueChoice reserves the right to pay either the Member or the provider. If the Member has paid the health care provider for services rendered, benefits will be payable to the Member.

6.3 No Assignment. A Member cannot assign any benefits or payments due under this In-Network Agreement to any person, corporation or other organization, except as specifically provided by this In-Network Agreement or as required by law.

6.4 Legal Actions. A Member cannot bring any lawsuit against CareFirst BlueChoice to recover under this Agreement before the expiration of sixty (60) days after written proof of loss has been furnished, and not after three (3) years from the date that written proof of loss is required to be submitted to CareFirst.

6.5 Events Outside of CareFirst's Control. If CareFirst BlueChoice, for any reason beyond the control of CareFirst BlueChoice , is unable to provide the coverage promised in Agreement, CareFirst is liable for reimbursement of the expenses necessarily incurred by any Member in procuring the services through other providers, to the extent prescribed by law.

6.6 Physical Examination and Autopsy. CareFirst at its own expense, has the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

6.7 Identification Card. Any cards issued to Members are for identification only.

A. Possession of an identification card confers no right to benefits.

B. To be entitled to such benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable Premiums have actually been paid.

C. Any person receiving benefits to which he or she is not then entitled will be liable for the actual cost of such benefits.

6.8 Member Medical Records. It may be necessary to obtain Member medical records and information from hospitals, Skilled Nursing Facilities, physicians or other practitioners who treat the Member. When a Member becomes covered, the Member (and if the Member is legally incapable of giving such consent, the representative of such Member) automatically gives CareFirst BlueChoice permission to obtain and use such records and information, including medical records and information requested to assist CareFirst BlueChoice in determining benefits and eligibility of Members.

6.9 Member Privacy. ~~CareFirst BlueChoice shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable financial, medical or health related data. In that regard, CareFirst BlueChoice will not provide to unauthorized third parties any personally identifiable financial or medical information without the prior written authorization of the patient or parent/guardian of the patient or as otherwise permitted by law. Personal information, including email addresses and phone numbers, may be used and shared with other businesses who work with CareFirst BlueChoice to administer and/or provide benefits under this plan. Personal information may also be used to notify enrollees about treatment options, health-related services, and/or coverage options. Enrollees may contact CareFirst BlueChoice to change the information used to communicate with them.~~ CareFirst BlueChoice shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable financial, medical or health related data. In that regard, CareFirst BlueChoice will not provide to unauthorized third parties any personally identifiable financial or medical information without the prior written authorization of the Member or parent/guardian of the Member or as otherwise permitted by law. Personal information, including email addresses and phone numbers, may be used and shared with other businesses who work with CareFirst BlueChoice to administer and/or provide benefits under this plan. Personal information, as described below, may also be used to notify enrollees about treatment options, health-related services, and/or coverage options. Enrollees may contact CareFirst BlueChoice to change the information used to communicate with them.

The more complete information health care providers have, the better they can meet the Members' health care needs. Sharing information and data with the Member's treating providers can lead to better coordinated care, help the Member get timely care, limit duplicative services, and help the provider better identify patients who would benefit most from care management and other care coordination programs.

How we use medical information to enhance or coordinate the Member's care — In order to administer the Member's health benefits, CareFirst BlueChoice receives claims data and other information from the Member's various providers of care regarding diagnoses, treatments, programs and services provided under your health plan. Individual treating providers, however, may not have access to information from the Member's other providers. When CareFirst BlueChoice has such information, it may share it with the Member's treating providers through secure, electronic means solely for purposes of enhancing or coordinating the Member's care and to assist in clinical decision making.

The Member may Opt-Out of information sharing by CareFirst BlueChoice for these care coordination purposes. The Member has the right to opt-out of the sharing of this information by CareFirst BlueChoice with his/her treating provider for care coordination purposes at any time. To opt-out, the Member must complete, sign and return the Opt-Out of Medical Information Sharing Form found at www.CareFirst BlueChoice.com/informationsharing. When the Member submits this form, the Member also ends participation in any of the programs listed in this Agreement that require the sharing of information to enhance or coordinate care. If the Member opts out, his/her treating providers will not have access to the data or information CareFirst BlueChoice has available to help enhance or coordinate his/her care.

~~6.9~~

6.10 CareFirst's Relationship to Providers. Health care providers, including Contracting Providers, Preferred Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers, are independent contractors or organizations and are related to CareFirst BlueChoice by contract only. Contracting Providers, Preferred Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers are not employees or agents of CareFirst BlueChoice and are not authorized to act on behalf of or obligate CareFirst BlueChoice with regard to interpretation of the terms of the In-Network Agreement, including eligibility of Members for coverage or entitlement to benefits. Contracting Providers, Preferred Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers maintain a provider-patient relationship with the Member and are solely responsible for the professional services they provide. CareFirst BlueChoice is not responsible for any acts or omissions, including those involving malpractice or wrongful death of Contracting Providers, Preferred Dentists, Contracting Vision Providers, Contracting Pharmacy Providers, or any other individual, facility or institution which provides services to Members or any employee, agent or representative of such providers.

6.11 Provider and Services Information. Listings of current Contracting Providers, Preferred Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers will be made available to Members at the time of enrollment. Updated listings are available to Members upon request. The listing of Contracting Providers, Preferred Dentists, Contracting Vision Providers and Contracting Pharmacy Providers is updated every fifteen (15) days on the CareFirst BlueChoice website (www.carefirst.com).

6.12 Administration of Agreement. CareFirst BlueChoice may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

6.13 Rules for Determining Dates and Times. The following rules will be used when determining dates and times:

A. All dates and times of day will be based on the dates and times applicable to the Washington, DC area, i.e., Eastern Standard Time or Eastern Daylight Savings Time, as applicable.

B. When reference is made to coverage being effective on a particular date, this means 12:01 a.m. on that date.

C. When reference is made to termination being effective on a particular date, this means 12:00 midnight on that date.

D. "Days" mean calendar days, including weekends, holidays, etc., unless otherwise noted.

E. "Year" refers to Calendar Year, unless a different benefit year basis is specifically stated.

6.14 Notices.

A. To the Member. Notice to Members will be sent via electronic mail, if the Member has consented to receive such notices via electronic mail, or by first class mail to the most recent address or electronic address for the Member in CareFirst BlueChoice's files. The

notice will be effective on the date mailed, whether or not the Member in fact receives the notice or there is a delay in receiving the notice.

B. To CareFirst BlueChoice. When notice is sent to CareFirst BlueChoice, it must be sent by first class mail to:

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065

1. Notice will be effective on the date of receipt by CareFirst BlueChoice, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service.

2. CareFirst BlueChoice may change the address at which notice is to be given by giving written notice thereof to the Subscriber

6.15 Amendment Procedure. Amendments must be consistent with federal and state law. Except for Premium rate changes, CareFirst will amend this Agreement to implement modifications by mailing a notice of the amendment(s) to the Subscriber, via first class mail or electronically if the Member has consented to receive such notices via electronic mail. CareFirst BlueChoice will give at least sixty (60) days before the effective date of the amendment, unless the modification is mandated to conform with any applicable changes to state or federal law.

No agent or other person, except an officer of CareFirst BlueChoice, has the authority to waive any conditions or restrictions of the Agreement or to bind CareFirst BlueChoice by making any promise or representation or by giving or receiving any information. No change in the Agreement will be binding on CareFirst BlueChoice, unless evidenced by an amendment signed by an authorized representative of CareFirst BlueChoice.

6.16 Regulation of CareFirst. CareFirst BlueChoice is subject to regulation in the District of Columbia by the Department of Insurance, Securities and Banking pursuant to Title 31 of the District of Columbia Code and the District of Columbia Department of Health pursuant to Reorganization Plan No. 4 of 1996, as amended.

6.17 Records and Clerical Errors.

A. The Subscriber must furnish CareFirst BlueChoice with data and notifications required for coverage in the format approved by CareFirst BlueChoice .

B. Clerical errors in recording or reporting data will not alter this Agreement. Upon discovery, adjustments will be made to remedy the errors.

6.18 Applicable Law. This Agreement is entered into and is subject to the laws of the District of Columbia. All claims arising from this Agreement will be brought and maintained in the District of Columbia. The Academic Institution and Members consent to the jurisdiction of the District of Columbia for all actions arising from this Agreement.

6.19 Contestability of Agreement.

A. The Agreement may not be contested, except for nonpayment of Premium, after it has been in force for two (2) years from the date of issue;

B. Absent fraud, each statement made by an applicant or Member is considered to be a representation and not a warranty; and

C. A statement to effectuate coverage may not be used to avoid the coverage or reduce the benefits unless:

1. The statement is contained in a written instrument signed by the Subscriber or Member, and

2. A copy of the statement is given to the Subscriber or Member.

No statement contained within this provision precludes the assertion at any time of defenses based upon the person's ineligibility for coverage or upon other provisions in this Agreement.

6.20 Misstatement of Age. If the age of a Member has been misstated, all Premiums payable under this Agreement shall be equitably adjusted based on the Premium due based on the Member's correct age. If the correction of the Member's age results in an increase in the Premium due, the Subscriber shall pay CareFirst the increased Premium due by the next Premium Due Date after notification by CareFirst. If, due to the correction in the Member's age, a Subscriber has paid a Premium or portion of a Premium not due, CareFirst BlueChoice 's liability is limited to a refund, on request, of any excess Premium paid for the period during which the Member's age was misstated.

6.21 Notice of Address Change. The Subscriber must notify CareFirst BlueChoice within fifteen (15) days of a change in residence or change in e-mail address, if the Member has consented to receive notices via electronic mail, or as soon as reasonably possible. Except in the case of a covered child who does not reside with the Subscriber, CareFirst BlueChoice is only responsible for mailing notices or correspondence to the last known physical address or e-mail address of the Subscriber.

6.22 Uniform Modification. CareFirst BlueChoice reserves the right to modify the In-Network Agreement at renewal if the modification is consistent with State law and is effective uniformly for all individuals with this product.

A. For purposes of this provision, modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered a uniform modification of coverage if:

1. The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement; and

2. The modification is directly related to the imposition or modification of the Federal or State requirement.

B. For purposes of this provision, other types of modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product meets all of the following criteria:

1. The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act);

2. The product is offered as the same product network type (for example, health maintenance organization, Preferred Provider organization, exclusive provider organization, point of service, or indemnity);

3. The product continues to cover at least a majority of the same service area;

4. Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act; and

5. The product provides the same covered benefits, except for any changes in benefits that cumulatively impact rate for any plan within the product within an allowable variation of ± 2 percentage points (not including changes pursuant to applicable Federal or State requirements).

6.23 Amendment Procedure. Except for Premium rate changes, CareFirst BlueChoice will amend this In-Network Agreement to implement modifications made pursuant to Section 6.22 by mailing a notice of the amendment(s) to the Subscriber, via first class mail or electronically if the Member

has consented to receive such notices via electronic mail, before the date of the first day of the next annual open enrollment period.

If the material modification required by law is made at a time other than renewal, and if it affects the content of the summary of benefits and coverage, CareFirst BlueChoice will provide advance notice at least sixty (60) days before the effective date of the modification.

No agent or other person, except an officer of CareFirst BlueChoice, has the authority to waive any conditions or restrictions of the In-Network Agreement or to bind CareFirst BlueChoice by making any promise or representation or by giving or receiving any information. No change in the In-Network Agreement will be binding on CareFirst BlueChoice, unless evidenced by an amendment signed by an authorized representative of CareFirst BlueChoice.

6.24 Conformity with State Statutes. Any provision of this Agreement, which, on its Effective Date, is in conflict with the statutes of the jurisdiction in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

SERVICE AREA

CareFirst BlueChoice's Service Area is a clearly defined geographic area in which CareFirst BlueChoice has arranged for the provision of health care services to be generally available and readily accessible to Members. CareFirst BlueChoice will provide the Member with a specific description of the Service Area at the time of enrollment.

The Service Area is as follows: the District of Columbia; the state of Maryland; in the Commonwealth of Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the areas of Fairfax and Prince William Counties in Virginia lying east of Route 123.

If a Member temporarily lives out of the Service Area (for example, if a Dependent goes to college in another state), the Member may be able to take advantage of the CareFirst BlueChoice Away From Home Program. This Program may allow a Member who resides out of the Service Area for an extended period of time to utilize the benefits of an affiliated Blue Cross and Blue Shield HMO. This Program is not coordination of benefits. **A Member who takes advantage of the Away From Home Program will be subject to the rules, regulations and plan benefits of the affiliated Blue Cross and Blue Shield HMO.** If the Member makes a permanent move, he/she does not have to wait until the Annual Open Enrollment Period to change plans. Please call [888-452-6403] or visit [www.bcbs.com] for more information on the Away from Home Program.

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
(202) 479-8000

An independent licensee of the BlueCross and Blue Shield Association

ATTACHMENT C
IN-NETWORK SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Individual Enrollment Agreement.

Benefits for Covered Services, Covered Dental Services, and Covered Vision Services may be provided either under the In-Network Individual Enrollment Agreement or Out-of-Network Individual Enrollment Agreement. Benefits will not be provided for the same service or supply under both this In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. However, for certain services there are visit or other limitations. Where there is a benefit limitation, the benefit limitation is combined for both the In-Network Individual Enrollment Agreement and Out-of-Network Individual Enrollment Agreement.

CareFirst BlueChoice pays only for Covered Services, Covered Vision Services and Covered Dental Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Deductible, Copayment or Coinsurance. Services that are not listed in the In-Network Description of Covered Services, or are listed in the Exclusions and Limitations, are not Covered Services, Covered Vision Services or Covered Dental Services.

When determining the benefits, a Member may receive, CareFirst BlueChoice considers all provisions and limitations in the Individual Enrollment Agreement as well as its medical policies. When these conditions of coverage are not met or followed, payments for benefits may be denied. Certain utilization management requirements will also apply. When these requirements are not met, payments may be reduced or denied.

[STUDENT HEALTH PLAN DEDUCTIBLE
The In-Network Deductible of **[Variable A]** per Member per Benefit Period applies to all Student Health Center Services.]

IN-NETWORK DEDUCTIBLE
[The In-Network Individual Benefit Period Deductible is **[Variable A].** The In-Network Family Benefit Period Deductible is **[Variable A]**.] **Individual Coverage:** The Member must satisfy the In-Network Individual Deductible. **[Variable B]** [The In-Network Deductible and the Out-of-Network Deductible are separate amounts and do not contribute to one another.] [The Benefit Period Deductible will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.]
The benefit chart below states whether a Covered Service is subject to the In-Network Deductible. **The following amounts may <u>not</u> be used to satisfy the Benefit Period Deductible:** • Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available. ~~• Discounts, coupons, or other amounts from third parties, including manufacturer coupons and discount prescription card programs.~~ • Charges in excess of the Allowed Benefit. • Charges for services which are not covered under the Individual Enrollment Agreement or which exceed the maximum number of covered visits/days listed below. • Charges for Covered Services not subject to the Deductible. [• Charges for Prescription Drugs.] • Charges for Pediatric Vision Services or Pediatric Dental Services. • [• Charges incurred under the Out-of-Network Individual Enrollment Agreement.]

IN-NETWORK OUT-OF-POCKET MAXIMUM
The In-Network Individual Benefit Period Out-of-Pocket Maximum is **[Variable C]**. The In-Network Family Benefit Period Out-of-Pocket Maximum is **[Variable C]**. **Individual Coverage:** The Member must meet the Individual Out-of-Pocket Maximum. **[Variable D]**. [The In-Network Out-of-Pocket Maximum and the Out-of-Network Out-of-Pocket Maximum are separate amounts and do not contribute to one another.] [The Benefit Period Out-of-Pocket Maximum will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.]
These amounts apply to the Benefit Period In-Network Out-of-Pocket Maximum: • In-Network Copayments and Coinsurance for all Covered Services. [• In-Network Benefit Period Deductible.] • Prescription Drug Deductible • In-Network Pediatric Dental Deductible and In-Network Coinsurance for Covered Dental Services. When the Member has reached the Out-of-Pocket Maximum, no further Copayments, Coinsurance or Deductible will be required in that Benefit Period for Covered Services, Covered Dental Services and Covered Vision Services. **The following amounts may <u>not</u> be used to satisfy the Benefit Period Out-of-Pocket Maximum:** • Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available. If a Member selects a Brand Name Drug when a Generic Drug is available, manufacturer coupons and the difference between the price of the Brand Name Drug and the Generic Drug would not count towards the Out-of-Pocket Maximum. If the Brand Name Drug does not have a Generic Drug equivalent, then manufacturer coupons may count towards the Out-of-Pocket Maximum. ~~• Discounts, coupons, or other amounts from third parties, including manufacturer coupons and discount prescription card programs.~~ • Charges in excess of the Allowed Benefit, Prescription Drug Allowed Benefit, Vision Allowed Benefit and Pediatric Dental Allowed Benefit. • Charges for services which are not covered under the Individual Enrollment Agreement or which exceed the maximum number of covered visits/days listed below. • Charges incurred under the Out-of-Network Evidence of Coverage, except for Copayment, Coinsurance, and Deductible payments for essential health benefits provided by an Out-of-Network ancillary provider in an In-Network setting, as provided by 45 CFR § 156.230.

SERVICE	LIMITATIONS	BENEFITS Subject to Deductible	Student Health Center	In Network
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization. ~~**Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.**~~				
The Member is responsible for any applicable Deductible, Copayment or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider. The benefit chart below states whether a Covered Service is subject to the Member Copayment for Clinic Visits/ Outpatient Services rendered in a hospital, hospital clinic, or health care provider's office on a hospital campus ("Clinic Visit"). These providers may bill individually resulting in claims from both the hospital/facility and the physician or health care provider rendering care in the hospital/facility/clinic setting. It is the Member's responsibility to determine whether separate claims will be assessed. **[**The Deductible [and] [,] [Copayments] [or] [Coinsurance] will be waived for Ceovered Services rendered at the Student Health Center. Benefits for massage therapy provided at a Student Health Center are limited to two (2) visits per Benefit Period.] [Coverage at a Student Health Center is limited to Services available and provided at the Member's Student Health Center.]				
	OUTPATIENT FACILITY, OFFICE AND PROFESSIONAL SERVICES			
Physician's Office	Services rendered by Specialists in the disciplines listed below will be treated as PCP visits for Member payment purposes. • General internal medicine; • Family practice medicine; • General pediatric medicine; or • Geriatric medicine.	**[Variable E]** Specialist: **[Variable E]** [Clinic Visit: **[Variable E]]**	PCP: **[Variable F]** Specialist: **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.**]**	PCP: **[Variable F]** Specialist: **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.**]**

Outpatient Non-Surgical Services		**[Variable E]** Specialist: **[Variable F]** **[Clinic Visit: [Variable E]]**	PCP: **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or	PCP: **[Variable F]** Specialist: **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.**]**

	BENEFITS			
SERVICE	**LIMITATIONS**	**Subject to Deductible**	**Student Health Center**	**In Network**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization. ~~**Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.**~~				
Laboratory Tests, X-Ray/Radiology Services, Specialty Imaging and Diagnostic Procedures				
Non-Preventive Laboratory Tests (independent non-hospital laboratory)		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Non-Preventive Laboratory Tests (outpatient department of a hospital)		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Non-Preventive X-Ray/Radiology Services (independent non-hospital facility)		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Non-Preventive X-Ray/Radiology Services (outpatient department of a hospital)		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Non-Preventive Specialty Imaging (independent non-hospital facility)		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Non-Preventive Specialty Imaging (outpatient department of a hospital)		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Non-Preventive Diagnostic Testing except as otherwise specified (in an independent non-hospital facility)		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**

Non-Preventive Diagnostic Testing except		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**

	BENEFITS			
SERVICE	**LIMITATIONS**	**Subject to Deductible**	**Student Health Center**	**In Network**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization. ~~**Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.**~~				
as otherwise specified (in an outpatient department of a hospital)				
Sleep Studies (Member's home)		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Sleep Studies (office or freestanding facility)	Prior authorization is required.	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Sleep Studies (outpatient department of a hospital)	Prior authorization is required.	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Preventive Care – Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society or required by the Patient Protection and Affordable Care Act (PPACA), ~~-~~as well as 3-D mammogram and adjuvant breast cancer screening, as described in the Description of Covered Services				
Prostate Cancer Screening		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Colorectal Cancer Screening		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Breast Cancer Screening		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Pap Smear		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Human Papillomavirus Screening Test		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Laboratory Tests		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive X-Ray/Radiology Services		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Specialty Imaging		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Diagnostic Testing (except as otherwise specified)		No	No Copayment or Coinsurance	No Copayment or Coinsurance

	BENEFITS			
SERVICE	**LIMITATIONS**	**Subject to Deductible**	**Student Health Center**	**In Network**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization. ~~**Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.**~~				
Immunizations		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Well Child Care		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Adult Preventive Care		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Women's Preventive Services		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Office Visits for Treatment of Obesity		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Professional Nutritional Counseling and Medical Nutrition Therapy		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Treatment Services				
Family Planning				
Non-Preventive Gynecological Office Visits		Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	Professional: **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Contraceptive Counseling		**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance
Contraceptive Drugs and Devices	Coverage of self-administered contraceptive drugs and devices is provided under the Prescription Drugs benefit.	**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance

Insertion or removal, and any Medically Necessary examination associated with	Drug or device must be approved by the FDA as a contraceptive.	**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance

BENEFITS				
SERVICE	**LIMITATIONS**	**Subject to Deductible**	**Student Health Center**	**In Network**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization. ~~**Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.**~~				
the use of any contraceptive devices or drugs				
Elective Sterilization Services – Female Members	Benefits available to female Members with reproductive capacity only.	**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance
Maternity and Related Services				
Preventive Visit		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Non-Preventive Visit		**[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	Professional: **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Professional Services for Delivery		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**

Infertility Treatment				
Infertility Counseling and Testing		Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	Professional: **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Allergy Services				
Allergy Testing and Allergy Treatment		Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	Professional: **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Allergy Shots		Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Rehabilitation Services				
Rehabilitative Physical Therapy	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a	**[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

			hospital or hospital clinic.]	
Rehabilitative Occupational Therapy	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Rehabilitative Speech Therapy	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Spinal Manipulation Services	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Habilitative Services for Children	Limited to Members under the age of 21.	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

Habilitative Services for Adults	Benefits available for Member age 21 and older. [Limited to **[Variable G]** visits per condition per Benefit Period for Physical Therapy, **[Variable G]** visits per condition per Benefit Period for Occupational Therapy and **[Variable G]** visits per condition per Benefit Period for Speech Therapy .] ~~Prior authorization is required for Habilitative services for Adults.~~	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	[Professional:] **[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable G]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Acupuncture		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic and there is a separate claim for the hospital/facility.]	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic and there is a separate claim for the hospital/facility.]
Cardiac Rehabilitation	[Limited to 90 days per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

Pulmonary Rehabilitation	Limited to one pulmonary rehabilitation program per lifetime combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Other Treatment Services				
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation [~~,~~and] pulmonary rehabilitation [and Infusion Services])		Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]	**[Variable F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

Blood and Blood Products		Professional: **[Variable E]**	Benefits are available to the same extent as benefits provided for other [infusion] services	
Clinical Trials	~~Prior authorization is required~~	Benefits are available to the same extent as benefits provided for other services		
Retail Health Clinic		**[Variable E]**	**[Variable F]**	**[Variable F]**
Telemedicine Services	Benefits are available to the same extent as benefits provided for other services			
Infusion Therapy				
Physician's Office	~~Prior authorization is required for Specialty Drugs in the Prescription Guidelines.~~	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Free-Standing Infusion Center	~~Prior authorization is required for Specialty Drugs in the Prescription Guidelines.~~	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Hospital Outpatient Department	~~Prior authorization is required for Specialty Drugs in the Prescription Guidelines.~~	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Member's Home	~~Prior authorization is required for Specialty Drugs in the Prescription Guidelines.~~	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Outpatient Surgical Facility and Professional Service				
Surgical Care at an Ambulatory Care Facility		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Outpatient Surgical Professional Services Provided at an Ambulatory Care Facility	**[Variable I]**~~Routine/Screening Colonoscopy is not subject to the Copayment.~~	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Surgical Care at an Outpatient Hospital Facility		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Outpatient Surgical Professional Services Provided at an	**[Variable I]**~~Routine/Screening Colonoscopy is not subject to the Copayment or Deductible.~~	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**

Outpatient Hospital				
INPATIENT HOSPITAL SERVICES				
Inpatient Facility (medical or surgical condition, including maternity and rehabilitation)	[Hospitalization solely for rehabilitation limited to ninety (90) days per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.] ~~Prior authorization is required except for emergency admissions and all maternity admissions.~~	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Inpatient Professional Services		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Organ and Tissue Transplants	Except for corneal transplants and kidney transplants, prior authorization is required.	Benefits are available to the same extent as benefits provided for other services		
SKILLED NURSING FACILITY SERVICES				
Skilled Nursing Facility Services	[Limited to **[Variable J]** ~~60~~ days per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.] ~~Prior authorization is required.~~F	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
HOME HEALTH SERVICES				
Home Health Services	~~Prior authorization is required~~. [Limited to ninety (90) visits per "episode of care" combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. A new episode of care begins if the Member does	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**

	not receive Home Health Care for the same or a different condition for sixty (60) consecutive days.]			
Postpartum Home Visits	Benefits are available to all Members.	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
HOSPICE SERVICES				
Inpatient Care	~~Prior authorization is required.~~ [Services limited to a maximum one hundred eighty (180) day hospice eligibility period] [Limited to sixty (60) days per hospice eligibility period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.]	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Outpatient Care	~~Prior authorization is required.~~ [Services limited to a maximum one hundred eighty (180) day hospice eligibility period.]	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Respite Care	~~Prior authorization is required.~~ [Services limited to a maximum one hundred eighty (180) day hospice eligibility period.]	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Bereavement Services	~~Prior authorization is required.~~ Covered only if provided within ninety (90) days following death of the deceased.	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES				
Outpatient Services				
Office Visits		**[Variable E]**	**[Variable F]**	**[Variable F]**
Outpatient Hospital Facility Services		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Outpatient Professional Services Provided at an Outpatient Hospital Facility		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Outpatient Psychological and Neuro-psychological Testing for Diagnostic Purposes		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Methadone Maintenance		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Partial Hospitalization		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Professional Services at a Partial Hospitalization Facility		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Inpatient Services				
Inpatient Facility Services	~~Prior authorization is required except for emergency admissions.~~	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Inpatient Professional Services		**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
EMERGENCY SERVICES AND URGENT CARE				
Urgent Care Facility	Limited to unexpected, urgently required services.	**[Variable E]**	**[Variable F]**	**[Variable F]**
Hospital Emergency Room - Facility Services	Limited to Emergency Services or unexpected, urgently required services.	**[Variable E]**	**[Variable F]**	**[Variable F]** [Waived if admitted]
Hospital Emergency Room – Professional Services	Limited to Emergency Services or unexpected, urgently required services.	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Follow-Up Care after Emergency Surgery	Limited to Emergency Services or unexpected, urgently required services.	Benefits are available to the same extent as benefits provided for other services		

Ambulance Service	~~Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency.~~	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
MEDICAL DEVICES AND SUPPLIES				
Durable Medical Equipment	~~Prior authorization is required for the Covered Services listed in Section 10.2 of the Description of Covered Services.~~	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Hair Prosthesis	Limited to one per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Breastfeeding Equipment and Supplies		**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance
Diabetes Equipment	Coverage for Diabetes Supplies will also be provided under the Prescription Drug benefit.	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Hearing Aids				
Hearing Aids	Limited to one hearing aid for each hearing-impaired ear every 36 months.	**[Variable E]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]**
Hearing Aid Related Services		**[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable ~~G~~F]**	**[Variable ~~G~~F]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
[WELLNESS BENEFIT				
[Health Risk Assessment		**[Variable E]**	No	No Copayment or Coinsurance]
[Health Risk Assessment Feedback		**[Variable E]**	No	No Copayment or Coinsurance]]
~~**PATIENT-CENTERED MEDICAL HOME**~~				

Associated Costs for the Patient Centered Medical Home Program (PCMH)	Benefits will be provided as described in the Description of Covered Services for Patient Centered Medical Home.	**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance
[TOTAL CARE AND COST IMPROVEMENT, HEALTH PROMOTION, WELLNESS AND DISEASE MANAGEMENT				
[TCCI Program Elements	Benefits will be provided as described in the Total Care and Cost Improvement, Health Promotion, Wellness and Disease Management Program Amendment.	**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance]
[Services Provided Pursuant to an Active Plan of Care under the BHCC Program, CCC Program, or SUD Program	Benefits will be provided as described in the Total Care and Cost Improvement, Health Promotion, Wellness and Disease Management Program Amendment. Members may simultaneously participate in the CCC Program and either the SUD Program or the BHCC Program, but no Member may simultaneously participate in all three Programs.	**[Variable E]**	No Copayment or Coinsurance	No Copayment or Coinsurance]
[Health Promotion and Wellness	Benefits will be provided as described in the Total Care and Cost Improvement, Health Promotion, Wellness and Disease Management Program Amendment.	No	No Copayment or Coinsurance	No Copayment or Coinsurance]
[Disease Management	Benefits will be provided as described in the Total Care and Cost Improvement, Health Promotion, Wellness and Disease Management Program Amendment.	No	No Copayment or Coinsurance	No Copayment or Coinsurance]]

PRESCRIPTION DRUGS					
SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	STUDENT HEALTH CENTER	MEMBER PAYS	
				CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
• Except for Emergency Services and Urgent Care outside the Service Area, when Prescription Drugs are purchased from a non-Contracting Pharmacy Provider, charges above the Prescription Drug Allowed Benefit are a non-Covered Service. • If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment when Medically Necessary, as determined by CareFirst BlueChoice. • A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects. ▲ [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Prescription Drug Deductible. • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines ▲ [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Deductible stated in this Schedule of Benefits.]					
[Prescription Drug Deductible					
The Prescription Drug Deductible is [Variable KH] per Member per Benefit Period.]					

PRESCRIPTION DRUGS					
		SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	STUDENT HEALTH CENTER	MEMBER PAYS	
SERVICE	LIMITATIONS			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
Covered Prescription Drugs	Limited to a [30-34]-day supply per prescription or refill.	Preventive Drugs: **[Variable ~~I~~E]** **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs: ~~Diabetic Supplies, Oral Chemotherapy Drugs:~~ [Variable ~~I~~E]** Generic Drugs: **[Variable ~~I~~E]** Preferred Brand Name Drugs: **[Variable ~~I~~E]** Non-Preferred Brand Name Drugs: **[Variable ~~I~~E]**	Preventive Drugs: No Copayment or Coinsurance **~~[Variable J]~~** **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs: ~~Diabetic Supplies and Oral Chemotherapy Drugs:~~ [Variable ~~J~~L]** Generic Drugs: **[Variable ~~J~~L]** per prescription or refill Preferred Brand Name Drugs: **[Variable ~~J~~L]** per prescription or refill Non-Preferred Brand Name Drugs: **[Variable ~~J~~L]** per prescription or refill]	Preventive Drugs: No Copayment or Coinsurance **~~[Variable J]~~** **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs: ~~Diabetic Supplies and Oral Chemotherapy Drugs:~~ [Variable ~~J~~L]** Generic Drugs: **[Variable ~~J~~L]** per prescription or refill Preferred Brand Name Drugs: **[Variable ~~J~~L]** per prescription or refill Non-Preferred Brand Name Drugs: **[Variable ~~J~~L]** per prescription or refill	

Maintenance Drugs	Limited to a [90-102]-day supply per prescription or refill. A Member may obtain up to a twelve (12) month supply of contraceptives at one time. Maintenance Drug means a Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.	Preventive Drugs: **[Variable ~~I~~E]** **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs:** ~~Diabetic Supplies, Oral Chemotherapy Drugs:~~ **[Variable ~~I~~E]** Generic Drugs: **[Variable ~~I~~E]** Preferred Brand Name Drugs: **[Variable ~~I~~E]** Non-Preferred Brand Name Drugs: **[Variable ~~I~~E]**	Preventive Drugs: No Copayment or Coinsurance ~~**[Variable K]**~~ **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs:** ~~Diabetic Supplies and Oral Chemotherapy Drugs~~: **[Variable ~~K~~M]** Generic Drugs: **[Variable ~~K~~M]** per prescription or refill Preferred Brand Name Drugs: **[Variable ~~K~~M]** per prescription or refill Non-Preferred Brand Name Drugs: **[Variable ~~K~~M]** per prescription or refill	**Preventive Drugs:** No Copayment or Coinsurance ~~**[Variable K]**~~ **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs:** ~~Diabetic Supplies and Oral Chemotherapy Drugs:~~ **[Variable ~~K~~M]** Generic Drugs: **[Variable ~~K~~M]** per prescription or refill Preferred Brand Name Drugs: **[Variable ~~K~~M]** per prescription or refill Non-Preferred Brand Name Drugs; **[Variable ~~K~~M]** per prescription or refill

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	STUDENT HEALTH CENTER	MEMBER PAYS	
				CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS					
Covered Specialty Drugs	Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network. Coverage for Specialty Drugs will **not** be provided when a Member purchases Specialty Drugs from a Pharmacy **outside** of the Exclusive Specialty Pharmacy Network.	**[Variable ~~I~~E]**	**[Preferred Specialty Drugs: [Variable ~~J~~L]** per ~~prescription or re~~fill for up to a [30-34]-day supply ~~of a non-Maintenance Drug~~ **[Variable ~~K~~M]** per ~~prescription or re~~fill for up to a [90-102]-day supply ~~of a Maintenance Drug~~ **Non-Preferred Specialty Drugs: [Variable ~~J~~L]** per ~~prescription or re~~fill for up to a [30-34]-day supply ~~of a non-Maintenance Drug~~ **[Variable ~~K~~M]** per ~~prescription or re~~fill for up to a [90-102]-day supply ~~of a Maintenance Drug~~]	**Preferred Specialty Drugs:** **[Variable ~~J~~L]** per ~~prescription or re~~fill for up to a [30-34]-day supply ~~of a non-Maintenance Drug~~ **[Variable ~~K~~M]** per ~~prescription or re~~fill for up to a [90-102]-day supply ~~of a Maintenance Drug~~ **Non-Preferred Specialty Drugs:** **[Variable ~~J~~L]** per ~~prescription or re~~fill for up to a [30-34]-day supply ~~of a non-Maintenance Drug~~ **[Variable ~~K~~M]** per ~~prescription or re~~fill for up to a [90-102]-day supply ~~of a Maintenance Drug~~	

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
Eye Examination	Limited to one per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance.
Lenses - Important note regarding Member Payments: "Basic" means spectacle lenses with no "add-ons" such as glare resistant treatment, ultraviolet coating, progressive lenses, transitional lenses and others which may result in additional costs to the Member.			
Basic Single vision	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Basic Bifocals	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Basic Trifocals	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Basic Lenticular	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Frames			
Frames	Limited to one frame per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. Limited to frames contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
Low Vision			
Low Vision Eye Examination	Prior authorization is required. Limited to one comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5-year period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	Expenses in excess of the Vision Allowed Benefit of **[Variable N]** are a non-Covered Vision Service~~No Copayment or Coinsurance.~~
Follow-up care	Prior authorization required. Limited to four visits in any five-year period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	Expenses in excess of the Vision Allowed Benefit of **[Variable N]** are a non-Covered Vision Service~~No Copayment or Coinsurance.~~
High-power Spectacles, Magnifiers and Telescopes	Prior authorization is required. Limited to a lifetime maximum of $1,200.	No	Expenses in excess of the Vision Allowed Benefit of **[Variable N]** are a non-Covered Vision Service~~No Copayment or Coinsurance.~~
Contact Lenses			
Elective	Includes evaluation, fitting and follow-up fees. Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. Limited to contact lenses contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance
Medically Necessary	Prior authorization is required. Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-	No	No Copayment or Coinsurance

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
	Network Individual Enrollment Agreement.		

Adult Vision – For Members age 19 and older			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE ?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
Eye Examination	Limited to one per Benefit Period.	No	**[Variable ~~L~~N]** ~~per exam~~

Pediatric Dental – Limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Dental Services up to the end of the Calendar Year in which the Member turns age 19.
Pediatric Dental Deductible
The In-Network Deductible of [**Variable ~~H~~K]** per Member per Benefit Period applies to all Class II, III, and IV Covered Dental Services.
Pediatric Dental Out-of-Pocket Maximum
Amounts paid by the Member for Covered Pediatric Dental Services will be applied to the In-Network Out-of-Pocket Maximum stated above. Once the In-Network Out-of-Pocket Maximum has been reached, the Member will no longer be required to pay any Deductible or Coinsurance.

SERVICE	**LIMITATIONS**	**SUBJECT TO PEDIATRIC DENTAL DEDUCTIBLE?**	**MEMBER PAYS**
			PREFERRED DENTIST
Class I Preventive & Diagnostic Services		**[Variable ~~I~~E]**	**[Variable ~~M~~O]**
Class II Basic Services		**[Variable ~~I~~E]**	**[Variable ~~M~~O]**
Class III Major Services – Surgical		**[Variable ~~I~~E]**	**[Variable ~~M~~O]**
Class IV Major Services – Restorative		**[Variable ~~I~~E]**	**[Variable ~~M~~O]**
Class V Orthodontic Services	Limited to Medically Necessary Orthodontia	**[Variable ~~I~~E]**	**[Variable ~~M~~O]**

CareFirst BlueChoice, Inc.
[Signature]

_____

[Name]
[Title]

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
(202) 479-8000

An independent licensee of the BlueCross and Blue Shield Association

ATTACHMENT C
IN-NETWORK SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Individual Enrollment Agreement.

Benefits for Covered Services, Covered Dental Services, and Covered Vision Services may be provided either under the In-Network Individual Enrollment Agreement or Out-of-Network Individual Enrollment Agreement. Benefits will not be provided for the same service or supply under both this In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. However, for certain services there are visit or other limitations. Where there is a benefit limitation, the benefit limitation is combined for both the In-Network Individual Enrollment Agreement and Out-of-Network Individual Enrollment Agreement.

CareFirst BlueChoice pays only for Covered Services, Covered Vision Services and Covered Dental Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Deductible, Copayment or Coinsurance. Services that are not listed in the In-Network Description of Covered Services, or are listed in the Exclusions and Limitations, are not Covered Services, Covered Vision Services or Covered Dental Services.

When determining the benefits a Member may receive, CareFirst BlueChoice considers all provisions and limitations in the Individual Enrollment Agreement as well as its medical policies. When these conditions of coverage are not met or followed, payments for benefits may be denied. Certain utilization management requirements will also apply. When these requirements are not met, payments may be reduced or denied.

[STUDENT HEALTH PLAN DEDUCTIBLE
The In-Network Deductible of **[Variable A]** per Member per Benefit Period applies to all Student Health Center Services.]

IN-NETWORK DEDUCTIBLE
[The In-Network Individual Benefit Period Deductible is **[Variable A]**. The In-Network Family Benefit Period Deductible is **[Variable A]**.] **Individual Coverage:** The Member must satisfy the In-Network Individual Deductible. **[Variable B]** [The In-Network Deductible and the Out-of-Network Deductible are separate amounts and do not contribute to one another.] [The Benefit Period Deductible will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.]
The benefit chart below states whether a Covered Service is subject to the In-Network Deductible. **The following amounts may <u>not</u> be used to satisfy the Benefit Period Deductible:** • Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available. ~~• Discounts, coupons, or other amounts from third parties, including manufacturer coupons and discount prescription card programs.~~ • Charges in excess of the Allowed Benefit. • Charges for services which are not covered under the Individual Enrollment Agreement or which exceed the maximum number of covered visits/days listed below. • Charges for Covered Services not subject to the Deductible. [• Charges for Prescription Drugs.] • Charges for Pediatric Vision Services or Pediatric Dental Services. [• Charges incurred under the Out-of-Network Individual Enrollment Agreement.]

IN-NETWORK OUT-OF-POCKET MAXIMUM

The In-Network Individual Benefit Period Out-of-Pocket Maximum is **[Variable C]**.

The In-Network Family Benefit Period Out-of-Pocket Maximum is **[Variable C]**.

Individual Coverage: The Member must meet the Individual Out-of-Pocket Maximum.

[Variable D].

[The In-Network Out-of-Pocket Maximum and the Out-of-Network Out-of-Pocket Maximum are separate amounts and do not contribute to one another.]

[The Benefit Period Out-of-Pocket Maximum will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.]

These amounts apply to the Benefit Period In-Network Out-of-Pocket Maximum:

- In-Network Copayments and Coinsurance for all Covered Services.
- [In-Network Benefit Period Deductible.]
- [Prescription Drug Deductible]
- In-Network Pediatric Dental Deductible and In-Network Coinsurance for Covered Dental Services.

When the Member has reached the Out-of-Pocket Maximum, no further Copayments, Coinsurance or Deductible will be required in that Benefit Period for Covered Services, Covered Dental Services and Covered Vision Services.

The following amounts may <u>not</u> be used to satisfy the Benefit Period Out-of-Pocket Maximum:

- Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available. If a Member selects a Brand Name Drug when a Generic Drug is available, manufacturer coupons and the difference between the price of the Brand Name Drug and the Generic Drug would not count towards the Out-of-Pocket Maximum. If the Brand Name Drug does not have a Generic Drug equivalent, then manufacturer coupons may count towards the Out-of-Pocket Maximum.
- ~~Discounts, coupons, or other amounts from third parties, including manufacturer coupons and discount prescription card programs.~~
- Charges in excess of the Allowed Benefit, Prescription Drug Allowed Benefit, Vision Allowed Benefit and Pediatric Dental Allowed Benefit.
- Charges for services which are not covered under the Individual Enrollment Agreement or which exceed the maximum number of covered visits/days listed below.
- Charges incurred under the Out-of-Network Evidence of Coverage, except for Copayment, Coinsurance, and Deductible payments for essential health benefits provided by an Out-of-Network ancillary provider in an In-Network setting, as provided by 45 CFR § 156.230.

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization. ~~**Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.**~~			
The Member is responsible for any applicable Deductible, Copayment or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider. The benefit chart below states whether a Covered Service is subject to the Member Copayment for Clinic Visits/ Outpatient Services rendered in a hospital, hospital clinic, or health care provider's office on a hospital campus ("Clinic Visit"). These providers may bill individually resulting in claims from both the hospital/facility and the physician or health care provider rendering care in the hospital/facility/clinic setting. It is the Member's responsibility to determine whether separate claims will be assessed. **[**The Deductible [and] [,] [Copayments] [or] [Coinsurance] will be waived for ~~covered~~ Covered Services rendered at the Student Health Center. Benefits for massage therapy provided at a Student Health Center are limited to two (2) visits per Benefit Period.] [Coverage at a Student Health Center is limited to Services available and provided at the Member's Student Health Center.]			
OUTPATIENT FACILITY, OFFICE AND PROFESSIONAL SERVICES			
Physician's Office	Services rendered by Specialists in the disciplines listed below will be treated as PCP visits for Member payment purposes. • General internal medicine; • Family practice medicine; • General pediatric medicine; or • Geriatric medicine.	PCP: **[Variable E]** Specialist: **[Variable E]** Clinic Visit: **[Variable E]**	PCP: **[Variable F]** Specialist: **[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.**]**
Outpatient Non-Surgical Services		PCP: **[Variable E]** Specialist: **[Variable E]** Clinic Visit: **[Variable E]**	PCP: **[Variable F]** Specialist: **[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.**]**
Laboratory Tests, X-Ray/Radiology Services, Specialty Imaging and Diagnostic Procedures			
Non-Preventive Laboratory Tests (independent non-hospital laboratory)		**[Variable E]**	**[Variable ~~G~~F]**
Non-Preventive Laboratory Tests (outpatient department of a hospital)		**[Variable E]**	**[Variable ~~G~~F]**

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.~~**Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.**~~			
Non-Preventive X-Ray/Radiology Services (independent non-hospital facility)		**[Variable E]**	**[Variable FG]**
Non-Preventive X-Ray/Radiology Services (outpatient department of a hospital)		**[Variable E]**	**[Variable FG]**
Non-Preventive Specialty Imaging (independent non-hospital facility)		**[Variable E]**	**[Variable FG]**
Non-Preventive Specialty Imaging (outpatient department of a hospital)		**[Variable E]**	**[Variable FG]**
Non-Preventive Diagnostic Testing except as otherwise specified (in an independent non-hospital facility)		**[Variable E]**	**[Variable FG]**
Non-Preventive Diagnostic Testing except as otherwise specified (in an outpatient department of a hospital)		**[Variable E]**	**[Variable FG]**
Sleep Studies (Member's home)		**[Variable E]**	**[Variable FG]**
Sleep Studies (office or freestanding facility)	Prior authorization is required.	**[Variable E]**	**[Variable FG]**

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.~~**Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.**~~			
Sleep Studies (outpatient department of a hospital)	Prior authorization is required.	**[Variable E]**	**[Variable F~~G~~]**
Preventive Care – Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society or required by the Patient Protection and Affordable Care Act (PPACA),~~,~~ as well as 3-D mammogram and adjuvant breast cancer screening, as described in the Description of Covered Services			
Prostate Cancer Screening		No	No Copayment or Coinsurance
Colorectal Cancer Screening		No	No Copayment or Coinsurance
Breast Cancer Screening		No	No Copayment or Coinsurance
Pap Smear		No	No Copayment or Coinsurance
Human Papillomavirus Screening Test		No	No Copayment or Coinsurance
Preventive Laboratory Tests		No	No Copayment or Coinsurance
Preventive X-Ray/Radiology Services		No	No Copayment or Coinsurance
Preventive Specialty Imaging		No	No Copayment or Coinsurance
Preventive Diagnostic Testing (except as otherwise specified)		No	No Copayment or Coinsurance
Immunizations		No	No Copayment or Coinsurance
Well Child Care		No	No Copayment or Coinsurance
Adult Preventive Care		No	No Copayment or Coinsurance
Women's Preventive Services		No	No Copayment or Coinsurance
Office Visits for Treatment of Obesity		No	No Copayment or Coinsurance
Professional Nutritional Counseling and		No	No Copayment or Coinsurance

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.~~**Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.**~~			
Medical Nutrition Therapy			
Treatment Services			
Family Planning			
Non-Preventive Gynecological Office Visits		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable FG~~]~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Contraceptive Counseling		**[Variable E]**	No Copayment or Coinsurance
Contraceptive Drugs and Devices	Coverage of self-administered contraceptive drugs and devices is provided under the Prescription Drugs benefit.	**[Variable E]**	No Copayment or Coinsurance
Insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs	Drug or device must be approved by the FDA as a contraceptive.	**[Variable E]**	No Copayment or Coinsurance
Elective Sterilization Services – Female Members	Benefits available to female Members with reproductive capacity only.	**[Variable E]**	No Copayment or Coinsurance
Maternity and Related Services			
Preventive Visit		No	No Copayment or Coinsurance
Non-Preventive Visit		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable FG~~]~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Professional Services for Delivery		**[Variable E]**	**[Variable FG~~]~~**
Infertility Treatment			

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.~~**Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.**~~			
Infertility Counseling and Testing		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	Professional: **[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Allergy Services			
Allergy Testing and Allergy Treatment		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Allergy Shots		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Rehabilitation Services			
Rehabilitative Physical Therapy	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Rehabilitative Occupational Therapy	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Rehabilitative Speech Therapy	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization. ~~**Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.**~~			
Spinal Manipulation Services	[Limited to **[Variable G]** visits per condition per Benefit Period combined]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Habilitative Services for Children	Limited to Members under the age of 21.	[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Habilitative Services for Adults	Benefits available for Member age 21 and older. [Limited to **[Variable G]** visits per condition per Benefit Period for Physical Therapy, **[Variable G]** visits per condition per Benefit Period for Occupational Therapy and **[Variable G]** visits per condition per Benefit Period for Speech Therapy .] ~~Prior authorization is required for Habilitative services for Adults.~~	[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Acupuncture		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic and there is a separate claim for the hospital/facility.]
Cardiac Rehabilitation	[Limited to 90 days per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.]	Professional: **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

Pulmonary Rehabilitation	Limited to one pulmonary rehabilitation program per lifetime combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
Other Treatment Services			
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation[,;and] pulmonary rehabilitation [and Infusion Services])		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F]** **[and [Variable F~~G~~]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. See Prior Authorization Amendment for Covered Services that require prior authorization.~~**Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.**~~			
Blood and Blood Products		Benefits are available to the same extent as benefits provided for other [infusion] services	
Clinical Trials	~~Prior authorization is required~~	Benefits are available to the same extent as benefits provided for other services	
Retail Health Clinic		**[Variable E]**	**[Variable F]**
Telemedicine Services	Benefits are available to the same extent as benefits provided for other services		
[Infusion Therapy			
Physician's Office	~~Prior authorization is required for Specialty Drugs in the Prescription Guidelines.~~	**[Variable E]**	**[Variable FG~~]~~**
Free-Standing Infusion Center	~~Prior authorization is required for Specialty Drugs in the Prescription Guidelines.~~	**[Variable E]**	**[Variable FG~~]~~**
Hospital Outpatient Department	~~Prior authorization is required for Specialty Drugs in the Prescription Guidelines.~~	**[Variable E]**	**[Variable FG~~]~~**
Member's Home	~~Prior authorization is required for Specialty Drugs in the Prescription Guidelines.~~	**[Variable E]**	**[Variable FG~~]~~]**
Outpatient Surgical Facility and Professional Services			
Surgical Care at an Ambulatory Care Facility		**[Variable E]**	**[Variable FG~~]~~**
Outpatient Surgical Professional Services Provided at an Ambulatory Care Facility	**[Variable I]**~~Routine/Screening Colonoscopy is not subject to the Copayment.~~	**[Variable E]**	**[Variable FG~~]~~**
Surgical Care at an Outpatient Hospital Facility		**[Variable E]**	**[Variable FG~~]~~**
Outpatient Surgical Professional Services Provided at an Outpatient Hospital	**[Variable I]**~~Routine/Screening Colonoscopy is not subject to the Copayment or Deductible~~.	**[Variable E]**	**[Variable FG~~]~~**
INPATIENT HOSPITAL SERVICES			
Inpatient Facility (medical or surgical condition, including	[Hospitalization solely for rehabilitation limited to ninety (90) days per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.]	**[Variable E]**	**[Variable FG~~]~~**

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. **See Prior Authorization Amendment for Covered Services that require prior authorization.~~Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.~~**			
maternity and rehabilitation)	~~Prior authorization is required except for emergency admissions and all maternity admissions.~~		
Inpatient Professional Services		**[Variable E]**	**[Variable F~~G~~]**
Organ and Tissue Transplants	Except for corneal transplants and kidney transplants, prior authorization is required.	Benefits are available to the same extent as benefits provided for other services	
SKILLED NURSING FACILITY SERVICES			
Skilled Nursing Facility Services	[Limited to **[Variable J]**~~60~~ days per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.] ~~Prior authorization is required.~~F	**[Variable E]**	**[Variable F~~G~~]**
HOME HEALTH SERVICES			
Home Health Services	~~Prior authorization is required.~~F [Limited to ninety (90) visits per "episode of care" combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. A new episode of care begins if the Member does not receive Home Health Care for the same or a different condition for sixty (60) consecutive days.]	**[Variable E]**	**[Variable F~~G~~]**
Postpartum Home Visits	Benefits are available to all Members.	**[Variable E]**	**[Variable F~~G~~]**
HOSPICE SERVICES			
Inpatient Care	~~Prior authorization is required.~~ [Services limited to a maximum one hundred eighty (180) day hospice eligibility period] [Limited to sixty (60) days per hospice eligibility period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.]	**[Variable E]**	**[Variable F~~G~~]**
Outpatient Care	~~Prior authorization is required.~~ [Services limited to a maximum one hundred eighty (180) day hospice eligibility period.]	**[Variable E]**	**[Variable F~~G~~]**
Respite Care	~~Prior authorization is required.~~	**[Variable E]**	**[Variable F~~G~~]**

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. **See Prior Authorization Amendment for Covered Services that require prior authorization.~~Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.~~**			
	[Services limited to a maximum one hundred eighty (180) day hospice eligibility period.]		
Bereavement Services	~~Prior authorization is required.~~ Covered only if provided within ninety (90) days following death of the deceased.	**[Variable E]**	**[Variable F~~G~~]**
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES			
Outpatient Services			
Office Visits		**[Variable E]**	**[Variable F]**
Outpatient Hospital Facility Services		**[Variable E]**	**[Variable F~~G~~]**
Outpatient Professional Services Provided at an Outpatient Hospital Facility		**[Variable E]**	**[Variable F~~G~~]**
Outpatient Psychological and Neuro-psychological Testing for Diagnostic Purposes		**[Variable E]**	**[Variable F~~G~~]**
Methadone Maintenance		**[Variable E]**	**[Variable F~~G~~]**
Partial Hospitalization		**[Variable E]**	**[Variable F~~G~~]**
Professional Services at a Partial Hospitalization Facility		**[Variable E]**	**[Variable F~~G~~]**
Inpatient Services			
Inpatient Facility Services	~~Prior authorization is required except for emergency admissions.~~	**[Variable E]**	**[Variable F~~G~~]**
Inpatient Professional Services		**[Variable E]**	**[Variable F~~G~~]**
EMERGENCY SERVICES AND URGENT CARE			
Urgent Care Facility	Limited to unexpected, urgently required services.	**[Variable E]**	**[Variable F]**
Hospital Emergency Room - Facility Services	Limited to Emergency Services or unexpected, urgently required services.	**[Variable E]**	**[Variable F]** [Waived if admitted]

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice in accordance with state and federal requirements, where required. **See Prior Authorization Amendment for Covered Services that require prior authorization.~~Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice.~~**			
Hospital Emergency Room – Professional Services	Limited to Emergency Services or unexpected, urgently required services.	**[Variable E]**	**[Variable F~~G~~]**
Follow-Up Care after Emergency Surgery	Limited to Emergency Services or unexpected, urgently required services.	Benefits are available to the same extent as benefits provided for other services	
Ambulance Service	~~Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency.~~	**[Variable E]**	**[Variable F~~G~~]**
MEDICAL DEVICES AND SUPPLIES			
Durable Medical Equipment	~~Prior authorization is required for the Covered Services listed in Section 10.2 of the Description of Covered Services.~~	**[Variable E]**	**[Variable F~~G~~]**
Hair Prosthesis	Limited to one per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	**[Variable E]**	**[Variable F~~G~~]**
Breastfeeding Equipment and Supplies		**[Variable E]**	**No Copayment or Coinsurance**
Diabetes Equipment	Coverage for Diabetes Supplies will also be provided under the Prescription Drug benefit.	**[Variable E]**	**[Variable F~~G~~]**
Hearing Aids			
Hearing Aids	Limited to one hearing aid for each ~~hearing impaired~~hearing-impaired ear every 36 months.	**[Variable E]**	**[Variable F~~G~~]**
Hearing Aid Related Services		[Professional:] **[Variable E]** [Clinic Visit: **[Variable E]]**	**[Variable F~~G~~]** **[and [Variable ~~G~~F]** if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic.]
[WELLNESS BENEFIT			
[Health Risk Assessment		No	No Copayment or Coinsurance]
[Health Risk Assessment Feedback		No	No Copayment or Coinsurance]]
~~**PATIENT-CENTERED MEDICAL HOME**~~			

Associated Costs for the Patient – Centered Medical Home Program (PCMH)	Benefits will be provided as described in the Description of Covered Services for Patient – Centered Medical Home.	**[Variable E]**	No Copayment or Coinsurance
[TOTAL CARE AND COST IMPROVEMENT, HEALTH PROMOTION, WELLNESS AND DISEASE MANAGEMENT			
[TCCI Program Elements	Benefits will be provided as described in the Total Care and Cost Improvement, Health Promotion, Wellness and Disease Management Program Amendment.	**[Variable E]**	No Copayment or Coinsurance]
[Services Provided Pursuant to an Active Plan of Care under the BHCC Program, CCC Program, or SUD Program	Benefits will be provided as described in the Total Care and Cost Improvement, Health Promotion, Wellness and Disease Management Program Amendment. Members may simultaneously participate in the CCC Program and either the SUD Program or the BHCC Program, but no Member may simultaneously participate in all three Programs.	**[Variable E]**	No Copayment or Coinsurance]
[Health Promotion and Wellness	Benefits will be provided as described in the Total Care and Cost Improvement, Health Promotion, Wellness and Disease Management Program Amendment.	No	No Copayment or Coinsurance]
[Disease Management	Benefits will be provided as described in the Total Care and Cost Improvement, Health Promotion, Wellness and Disease Management Program Amendment.	No	No Copayment or Coinsurance]]

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• Except for Emergency Services and Urgent Care outside the Service Area, when Prescription Drugs are purchased from a non-Contracting Pharmacy Provider, charges above the Prescription Drug Allowed Benefit are a non-Covered Service. • If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment when Medically Necessary, as determined by CareFirst BlueChoice. • A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects. • [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Prescription Drug Deductible.] • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines. • [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Deductible stated in this Schedule of Benefits.]				
[Prescription Drug Deductible				
The Prescription Drug Deductible is [Variable KH] per Member per Benefit Period.]				

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• Except for Emergency Services and Urgent Care outside the Service Area, when Prescription Drugs are purchased from a non-Contracting Pharmacy Provider, charges above the Prescription Drug Allowed Benefit are a non-Covered Service. • If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment when Medically Necessary, as determined by CareFirst BlueChoice. • A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects. • [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Prescription Drug Deductible.] • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines. • [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Deductible stated in this Schedule of Benefits.]				
Covered Prescription Drugs	Limited to a [30-34]-day supply per prescription or refill.	Preventive Drugs **[Variable E~~I~~]** **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs:** ~~Diabetic Supplies, Oral Chemotherapy Drugs~~ **[Variable E~~I~~]** Generic Drugs: **[Variable E~~I~~]** Preferred Brand Name Drugs: **[Variable ~~I~~E]** Non-Preferred Brand Name Drugs: **[Variable E~~I~~]**	**Preventive Drugs:** No Copayment or Coinsurance ~~**[Variable J]**~~ **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs:** ~~**Diabetic Supplies and Oral Chemotherapy Drugs:**~~ **[Variable L~~J~~]** per prescription or refill **Generic Drugs: [Variable L~~J~~]** per prescription or refill **Preferred Brand Name Drugs: [Variable L~~J~~]** per prescription or refill **Non-Preferred Brand Name Drugs; [Variable L~~J~~]** per prescription or refill	

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• Except for Emergency Services and Urgent Care outside the Service Area, when Prescription Drugs are purchased from a non-Contracting Pharmacy Provider, charges above the Prescription Drug Allowed Benefit are a non-Covered Service. • If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment when Medically Necessary, as determined by CareFirst BlueChoice. • A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects. • [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Prescription Drug Deductible.] • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines. • [• Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Deductible stated in this Schedule of Benefits.]				
Maintenance Drugs	Limited to a [90-102]-day supply per prescription or refill. A Member may obtain up to a twelve (12) month supply of contraceptives at one time. Maintenance Drug means a Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.	Preventive Drugs **[Variable E~~I~~]** **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs:** ~~Diabetic Supplies, Oral Chemotherapy Drugs~~ **[Variable E~~I~~]** Generic Drugs: **[Variable E~~I~~]** Preferred Brand Name Drugs: **[Variable E~~I~~]** Non-Preferred Brand Name Drugs: **[Variable E~~I~~]**	**Preventive Drugs :** No Copayment or Coinsurance ~~**[Variable K]**~~ **Diabetic Supplies, Oral Chemotherapy Drugs and Medication Assisted Treatment Drugs:** ~~**Diabetic Supplies and Oral Chemotherapy Drugs:**~~ **[Variable M~~K~~]** per prescription or refill **Generic Drugs: [Variable M~~K~~]** per prescription or refill **Preferred Brand Name Drugs: [Variable M~~K~~]** per prescription or refill **Non-Preferred Brand Name Drugs; [Variable M~~K~~]** per prescription or refill	

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
Covered Specialty Drugs	Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network. Coverage for Specialty Drugs will **not** be provided when a Member purchases Specialty Drugs from a Pharmacy **outside** of the Exclusive Specialty Pharmacy Network.	**[Variable EI]**	**Preferred Specialty Drugs:** **[Variable LJ]** per ~~prescription or re~~fill for up to a [30-34]-day supply ~~of a non-Maintenance Drug~~ **[Variable MK]** per ~~prescription or re~~fill for up to a [90-102]-day supply ~~of a Maintenance Drug~~ **Non-Preferred Specialty Drugs:** **[Variable LJ] p**er ~~prescription or re~~fill for up to a [30-34]-day supply ~~of a non-Maintenance Drug~~ **[Variable MK]** per ~~prescription or re~~fill for up to a [90-102]-day supply ~~of a Maintenance Drug~~	

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
Eye Examination	Limited to one per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance.
Lenses - Important note regarding Member Payments: "Basic" means spectacle lenses with no "add-ons" such as glare resistant treatment, ultraviolet coating, progressive lenses, transitional lenses and others which may result in additional costs to the Member.			
Basic Single vision	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Basic Bifocals	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Basic Trifocals	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Basic Lenticular	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance
Frames			
Frames	Limited to one frame per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	No Copayment or Coinsurance

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
	Limited to frames contained in the Vision Care Designee's collection.		
Low Vision			
Low Vision Eye Examination	Prior authorization is required. Limited to one comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5-year period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	Expenses in excess of the Vision Allowed Benefit of **[Variable N]** are a non-Covered Vision Service~~No Copayment or Coinsurance.~~
Follow-up care	Prior authorization required. Limited to four visits in any five-year period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.	No	Expenses in excess of the Vision Allowed Benefit of **[Variable N]** are a non-Covered Vision Service~~No Copayment or Coinsurance.~~
High-power Spectacles, Magnifiers and Telescopes	Prior authorization is required. Limited to a lifetime maximum of $1,200.	No	Expenses in excess of the Vision Allowed Benefit of **[Variable N]** are a non-Covered Vision Service~~No Copayment or Coinsurance.~~
Contact Lenses			
Elective	Includes evaluation, fitting and follow-up fees. Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement. Limited to contact lenses contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance
Medically Necessary	Prior authorization is required.	No	No Copayment or Coinsurance

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
	Limited to one pair per Benefit Period combined under the In-Network Individual Enrollment Agreement and the Out-of-Network Individual Enrollment Agreement.		

Adult Vision – For Members age 19 and older			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS CONTRACTING VISION PROVIDER**
Eye Examination	Limited to one per Benefit Period.	No	**[Variable NL] ~~per exam~~**

Pediatric Dental – Limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Dental Services up to the end of the Calendar Year in which the Member turns age 19.
Pediatric Dental Deductible
The In-Network Deductible of **[Variable K~~H~~]** per Member per Benefit Period applies to all Class II, III, and IV Covered Dental Services.
Pediatric Dental Out-of-Pocket Maximum
Amounts paid by the Member for Covered Pediatric Dental Services will be applied to the In-Network Out-of-Pocket Maximum stated above. Once the In-Network Out-of-Pocket Maximum has been reached, the Member will no longer be required to pay any Deductible or Coinsurance.

SERVICE	LIMITATIONS	SUBJECT TO PEDIATRIC DENTAL DEDUCTIBLE?	MEMBER PAYS PREFERRED DENTIST
Class I Preventive & Diagnostic Services		**[Variable E~~I~~]**	**[Variable O~~M~~]**
Class II Basic Services		**[Variable E~~I~~]**	**[Variable O~~M~~]**
Class III Major Services – Surgical		**[Variable E~~I~~]**	**[Variable O~~M~~]**
Class IV Major Services – Restorative		**[Variable E~~I~~]**	**[Variable O~~M~~]**
Class V Orthodontic Services	Limited to Medically Necessary Orthodontia	**[Variable E~~I~~]**	**[Variable O~~M~~]**

CareFirst BlueChoice, Inc.
[Signature]

_____

[Name]
[Title]